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The Alberta Health Care Advantage: An Accessible, High Quality, and Sustainable System

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Executive Summary

In recent months, Alberta Premier Ralph Klein and Alberta Health Minister Gary Mar have said that Alberta is about to embark on "radical changes" to its health care system—which could include user fees or tax incentives for healthy behaviour—whether or not that means violating the Canada Health Act (Barrett, 2004).

Among the regulations comprising the Canada Health Act are sections 18 through 21, which effectively ban extra billing by physicians and user fees for services that are publicly insured. The federal government can reduce its payments to provinces that permit hospitals and physicians to charge patients in these ways. The introduction of user fees would bring Alberta into direct conflict with the federal legislation, resulting in possible financial penalties.

While the outspokenness of the premier and health minister on openly violating a piece of legislation that has become sacrosanct in Canada is surprising, the reforms they have put forward are not. Two and a half years ago, the Premier's Advisory Council on Health for Alberta, chaired by Don Mazankowski, delivered (by Canadian standards) a much more radical set of ideas to raise health care revenues and temper demand for health services in order to make the system sustainable. The list included user fees, risk-rated premiums, co-payments, deductibles, taxable benefits, medical savings accounts, and supplementary insurance (Premier's Advisory Council on Health, 2001).

However, most of the reforms suggested by the Mazankowski Report were less controversial and the province's action plan for improving the health care system, *Alberta: Health First, Building a Better Public Health Care System*, is based on the 44 recommendations made by the advisory council in December 2001. These included the setting of clear health objectives and targets, providing more information to Albertans, reducing waiting lists, encouraging primary care projects, evaluating the services covered by public insurance, investing in information technology and health research, improving incentives to help retain and make the best use of health providers, making the public sector accountable for health outcomes, and laying out a clear transition plan for reform. While the government has made progress on all of these items and others, it has made little headway on the more substantial, and arguably more essential, directions for change, such as diversifying the revenue stream, creating incentives for people to stay healthy, introducing more choice and competition into the system, and promoting health care as an important part of the Alberta economy.

Will *Health First* create a sustainable health care system?

In 2002/2003, the Alberta government spent $6.8 billion on health care, an 8.2 percent increase over 2001/2002 (Alberta Health and Wellness, 2003b). Since 1995, health spending in Alberta has increased by more than 80 percent, four times faster than all other government spending (Alberta Health and Wellness, 2003c). Currently, the government spends the highest portion of its budget on health care (about a third) and future increases of 5.7 percent and 3.8 percent will bring ministry spending to almost $8.8 billion by 2006/2007 (Government of Alberta, 2004b).

Alberta is already one of the biggest spenders per capita on health care in Canada, yet its health care

system relative to other provinces is not exemplary. Access to care seems to be a concern—waiting times are an issue, from GP to specialist and especially in the areas of orthopaedic and elective cardiovascular surgery. Yet the number of surgeries performed has been increasing, as have the number of physicians in the province. Even the proportion of registered nurses, while relatively low in Alberta, has been increasing, as has that of physicians.

While it is impressive that the ministry of health and the regional health authorities have set specific targets for so many aspects of health status, system quality, etc., many of the targets are not being met and the government strategies for improving the health of Albertans are ambiguous. The vast majority of ministry spending is directed to physicians, hospitals, long-term care, and other aspects of the health system, but increased funding in these areas over a number of years has yet to achieve any permanent reduction in waiting times or increased patient access to the system. Reforms are going to have to be more substantial, including changes to the way in which hospitals are funded, to create incentives for hospitals to treat more patients and to provide the types of services that patients desire.

As well, primary care teams, moving physicians off fee-for-service, and encouraging other practitioners to replace physicians will not necessarily save the health system money or provide patients with a higher quality of care. There is much evidence that replacing fee-for-service payments with either a salary or capitation payment reduces the number of services that providers offer, and that alternative practitioners performing doctors' duties wish to be paid accordingly. The encouraging aspect of Alberta's approach to primary care is that there is some competition built into the process, but it is unclear as to whether groups will be allowed to "go out of business" if they fail to meet their contractual obligations.

Another encouraging aspect of Alberta's reforms is the contracting out of certain surgical services to private facilities, but the overall impact of this policy, however, is minimal, as these contracts represent only 0.15 percent of provincial health spending (Alberta Health and Wellness, 2004h).

Meanwhile, most of the authorities reported deficits in 2002/2003 and the introduction of multi-year performance agreements between the ministry and the regions is not yet complete. The health authorities, while having a significant role in planning and providing for their regions' health needs, are still, ultimately, advisory bodies to the minister of health and, therefore, are limited in their ability to raise other revenues and be innovative. Despite all of Alberta's health reforms, the system still operates as a monopoly.

In addition to the general problems associated with monopolies, such as higher prices, slower adoption of technology, and poorer customer service, the impact of having only one employer in the health care sector—the government—makes labour issues more difficult to resolve without service disruption. The minimization of these costs is one of the reasons behind Alberta's recent passing of Bill 27, which reduces the number of bargaining units and introduces compulsory arbitration, among other changes. As well, the government has tried to increase labour market flexibility with the Health Professions Act, in which scopes of practice are no longer exclusive to one profession—to date, only 9 of 28 professions have regulations under force of the act (Alberta Health and Wellness, 2004a).

Despite all of the government's reform measures, the sustainability of Alberta's health system is still in question. This is why the premier and the health minister are talking about "radical changes" and why they are beginning to openly

discuss the possibility that the private sector may be able to ease some of the cost pressures on the public system.

There are various reasons why people would choose to use private health care, even if the same goods and services are provided by the public sector for a lower direct cost to consumers/patients. Given the multiplicity of demands on public sector budgets and, therefore, the need to ration care (using wait lists or only subsidizing certain goods and services), some people will look to the private sector for faster access to care, more choice in good and services, and the expectation of higher quality.

As is evidenced by the experience in Alberta and in other parts of the world, there are many ways in which the private sector can be involved in health care. On the supply side, from the government perspective, surgical or support services can be contracted out to the private sector, and the government can partner with the private sector to design, construct, finance, and operate hospitals. On the demand side, a range of health services could involve cost-sharing mechanisms such as user fees, deductibles, and co-payments, requiring individuals to "share" the cost of these goods and services with the insurer (public or private). The range of savings from implementing a cost-sharing program in Alberta is $831 million to $1.34 billion, depending on the population groups and expenditures exempted, while the potential penalties (lost federal transfers resulting from the violation of the Canada Health Act) range from $0 to $958 million. There is also the possibility of an option such as medical savings accounts, which could reduce expenditures by as much as 20 percent while providing other benefits such as more consumer choice, accumulated savings for future health needs, and increasing quality through competition. While these are perhaps overly optimistic outcomes of such reforms, they indicate that such ideas should be given due consideration.

Recommendations

The following policy recommendations are grouped into two categories: those that fall within the current bounds of the Canada Health Act, and those that would violate the act's sections on extra-billing and user charges, and the principle of public administration.

Recommendations that fall within the current bounds of the Canada Health Act:

- Privatize hospitals and other health facilities
- Define the roles of regulator, purchaser, and provider
- Introduce a new payment system for hospital/surgical services
- Remove all restrictions on medical school enrolment and withdraw subsidies for medical school education
- Consider public-private partnerships (P3s) for the construction and operation of new health services infrastructure
- Have citizens start a savings account for long-term care
- Open up access to all publicly held information on health care provider performance

Recommendations that would not be possible without violating the Canada Health Act:

- Remove any and all restrictions on a parallel private health care system
- Implement a cost-sharing structure within the public health care system in Alberta
- Move from the single-purchaser model to a system of many competitive insurers where individuals are required to be insured for a basic set of health services
- Deregulate the mandatory social insurance sector to permit the formation of medical savings accounts.

Section 1: Introduction

Alberta Premier Ralph Klein told the *Edmonton Journal* in April: "Some people are waiting too long for needed services. Costs are growing at twice the rate of our ability to fund the system." He also said that the sustainability of universal health care is the biggest challenge facing Canadians, but "what is unique about Alberta is that we are committed to fixing the problems as best we can" (Baxter, 2004).

In the same article, Alberta Health Minister Gary Mar dismissed the American health care system as a possible model for a "reformed" Alberta health system, but said private service delivery was the way to go. He gave the example of laser sight correction as to how private delivery can lower costs, saying that the cost of the surgery, which is done at private clinics, has dropped from about $5,000 an eye a decade ago to about $500 (Baxter, 2004).

These comments came days after a *Calgary Herald* article in which Mar said that, when it comes to health care reform, everything is on the table—from user fees, to progressive taxes, to tax incentives for healthy behaviour, such as quitting smoking. He had just presented the government caucus with a long list of ideas to help control increasing health care spending, but he and Klein shared no details except that a plan will be developed and released to the public by late June to see "whether people are ready for radical changes" (Barrett, 2004).

Given Alberta's relative wealth compared to other provinces, and the unexceptional nature of its health care system in the Canadian context, there are those who question the need for changes based on the sustainability argument (United Nurses of Alberta, 2004a). But the sustainability of Alberta's current system is possibly more at risk than that of the other provinces. Alberta's spending levels and low taxation rates are possible because of high resource royalty revenues. With conventional oil production declining and natural gas reserves depleting, Alberta's fiscal position will not necessarily be very good in as early as 10 years time, since synthetic crude production will not generate the same sorts of revenues. Other provinces have health care spending that reflects a reliance on tax finance, whereas Alberta will have to impose a sales tax, higher health premiums, or higher personal income taxes to maintain what it has now, let alone improve its system. All provinces will have to manage rising costs through rising taxes (or diminished public spending on health replaced by higher private spending), but Alberta will have to account for rising costs along with a disappearing source of revenue. This combination suggests that Alberta will face a bigger adjustment than other jurisdictions.

This is perhaps why Klein has said that Alberta will forge ahead with its reforms regardless of what other provinces say. "What happens in Alberta really is of no concern to the other premiers or health ministers, insofar as we make sure we live up to some of the fundamental principles of the Canada Health Act," he added (Barrett, 2004).

Among the five main tenets of the Canada Health Act (CHA) is that of accessibility, whereby the health care insurance plan of a province must provide for insured health services on uniform terms and on a basis that does not impede or preclude *reasonable* access to those services by insured persons. Separate from this principle are sections 18 through 21 of the act, which effectively ban user fees and extra billing. As a deterrent, the

federal government can reduce its payments to provinces that permit user fees and extra billing be physicians for services that are publicly insured.

Already, by contracting out certain publicly insured procedures to private health facilities, Alberta is seen by many people as violating the national health act—even though it is not. But Alberta would be contravening the provisions against extra billing and user charges contained within the act if it did implement user fees, so the key word in Klein's quote, perhaps, is that the province will live up to the CHA's fundamental principles, but not necessarily the specific rules and regulations surrounding them. The impetus for such controversial action and the possible consequences of it are two key aspects of this study, which begins with a brief discussion of the basic economics of health care and the implications of the CHA for meaningful health care reform in Canada.

Section 3 examines the current state of Alberta's health care system, providing an overview of cost, access, and quality. In this context, Section 4 analyzes the government's health plan—*Alberta: Health First, Building a Better Public Health Care System*—which is based on the 44 recommendations made by the Premier's Advisory Council on Health (chaired by Don Mazankowski) in December 2001. This section looks at how successful the plan has been in addressing the problems faced by the system.

Section 5 provides an overview of how health care is organized in several industrialized countries and, based on the international experience, Section 6 considers some of the options that the Alberta government may be considering in its proposal for "radical changes." Specifically, it focuses on the potential role for the private sector in health care, from service provision, to public-private partnerships (P3s) for the construction, financing and operation of new health infrastructure, to private (for-profit and not-for-profit) hospitals. All of these options are possible under the CHA, and Alberta has pursued them to varying degrees. This section also examines some of the ideas that the government has rejected to date, such as user fees and medical savings accounts, and details the potential consequences of the government choosing to violate the CHA and implement a cost-sharing program in Alberta.

Finally, Section 7 offers several policy recommendations as to how Alberta could improve its health care system, both within and outside of the confines of the CHA.

Section 2: The Basic Economics of Health Care

In Canada, the public sector—all levels of government and the Workers' Compensation Boards—accounted for a forecasted 69.9 percent of total health care spending in 2003; the private sector accounted for 30.1 percent (Canadian Institute for Health Information, 2003a).

Governments pay mainly for medically necessary services, which generally comprise acute care, physicians' fees, and a portion of pharmaceutical charges. Private sector spending includes money spent on health care providers other than doctors (for example, chiropractors), institutions other than hospitals (nursing homes and other facilities), pharmaceuticals, dental care, eye care, and private insurance premiums.

The current health care system in Canada has its origins in the 1948 Hospital Construction Grants Program, in which the federal government made grants available to the provinces for planning and hospital construction. In the 1968 Medical Care Act, medical services provided by a physician became insured by another federal-provincial cost-sharing program. To qualify for federal funding, a province's program had to be *universal* (cover all residents of a province), *portable* (cover residents of one province requiring medical services in another province), *comprehensive* (cover all medically necessary services) and *publicly administered* (a nonprofit program). The Canada Health Act (1984) added *accessibility* to the requirements, and the federal government tries to achieve this by reducing its payments to the provinces, on a dollar-for-dollar basis, by the amount of user fees charged by hospitals and extra billing by physicians.

In effect, for medically necessary services, the Canada Health Act attempts to separate people's financial contribution to the health system from their health risks and from their use of services. But is there really a need to do this?

The health care system and a population's health

A health care system generally encompasses, for the most part, acute care and physician services. However, there have been numerous studies, including by the World Health Organization, showing that there is little or no correlation between the health care system (spending) and a population's health status (Conference Board of Canada, 2004; Ramsay, 2001; WHO, 2000; Oxley and MacFarlan, 1994). This is why there are always policy discussions about redirecting resources to public health and primary care, as there is evidence that public access to sanitation, safe water, immunization, screening services such as mammograms, and other preventive care, have a positive effect on a population's health.

Given the tenuous connection between the health system and population health, governments really should focus on simply ensuring universal access to and the availability of basic health care. Beyond this, governments should be concerned only with ensuring that those who cannot afford to pay for medical services have access to them when they require care and, perhaps, requiring their citizens to purchase (public or private) health insurance for catastrophic events. However, because of the structure of the Canadian health care system and the entrenched position of health care providers, the majority of government health funding still goes to acute care services and its providers. This is largely due to the fact that the Canada Health Act applies to these services.

The idea of establishing multi-disciplinary health centres in which different providers (physicians, nurses, perhaps a nutritionist, chiropractor, naturopath, or other practitioner) would attempt to "service" the whole patient has been around for decades. As well, spending on physician services and acute care as a percent of the total health care budget has been decreasing over the last number of years. But "physician-centered solo and small group private practice remain the norm" (Canadian Institute for Health Information, 2002a) and hospital closures always meet with public outcry. Acute care expenditures still account for the largest portion of government health care expenditures—almost 39 percent in Alberta in 2003 (see table 3.5 for dollar figures).

As long as medically necessary services are under the purview of government only, more funding will be directed to physician and hospital services. As well, politically motivated actions such as keeping inefficient hospitals open to keep residents happy will remain commonplace. One can only guess at the opportunity cost (the life-improving and life-saving care forgone) of such decisions.

Insurance

There is no reason to use government intervention to separate the financing of health care from the risks of needing care. Insurance markets have developed in the health care sector, as they have in other markets, to deal with the uncertainty and risk of illness. People pay a fee to an insurer so that, in the case of a heart attack or an injury, the insurer will pay them a certain amount of money, thereby reducing the financial cost to them of such an event.

With insurance, society also benefits because many people share (pool) the risks. So when something terrible happens, an individual is compensated for their loss out of the fees paid to the insurer by everyone who insured themselves against this risk.

With health insurance, there is also a morality aspect: people who are not properly insured may not be able to afford care when they need it. However, there are problems when people do not face any direct charges for care. When a third party, either the government or a private insurance company, covers their medical expenses, people have no incentive to restrain their use of services. This is called moral hazard: insured patients demand more services than they would in the absence of insurance because the marginal cost of care to them is lower than if they did not have insurance. In insurance literature, moral hazard is often seen as a moral or ethical problem. However, Pauly notes that moral hazard is more a result of rational economic behaviour than of lower morality (Pauly, 1968). Individuals may recognize that their excessive use of health care will result in higher premiums or taxes, but their increase in benefits from over-consumption is large, while the incremental cost of their excessive use is small, because the entire population bears the cost. This situation can result in excessive demand and wasted resources, to the extent that the costs of producing these services are greater than what individuals would be willing to pay for them directly.

On the other hand, if people are not insured, they may delay seeking care, which may be more costly and harmful to their health, and even to the health of those around them, than if they had received more timely treatment or medical advice. The incentives to under use and to over use medical services must be balanced. It is for this reason that cost-sharing, such as co-payments and deductibles, has been introduced into the insurance market.

For those of us who are worried about the potential impact that such a connection may have on lower-income Canadians, any form of cost-sharing can be adjusted so as to protect this group from being denied the care they need because of an inability to pay for it. Catastrophic insurance, which is simply an insurance policy that has a high deductible, creates an incentive for people to restrain their use of health care services (however, once the deductible has been reached, medical care is, in essence, "free"). High deductibles may prevent or limit access to medical care; therefore, the optimal deductible faced by low-income people, or by people who are chronically ill, may be lower than that of other individuals, even zero. User fees and co-insurance rates also can be linked to income, and the chronically ill can be exempt from any cost sharing. Such mechanisms are already in place in many provincial pharmaceutical plans and, nationally, the GST credit system is an example of how those who cannot afford to contribute more financially are protected from such costs.

Proponents of user fees and cost sharing argue that, if required to bear a portion of their health care costs, individuals will curb their consumption of medical care, so medical services of lesser value eventually will be eliminated. As well, they maintain that fees can reduce the tax burden of Canadians because they redirect health care financing from taxpayers to users. Lastly, they believe that if the health system is more efficient and more funding comes directly from users rather than from taxpayers in general, then governments will be able to decrease the size of their health care budget. (For more detail on these and other arguments in favour of cost-sharing, see Ramsay, 1998; Gratzer, 1999; McMahon and Zelder, 2002.)

Opponents of cost sharing point out that, because of ignorance or cost concerns, individuals may delay seeking care or forgo preventive care when faced with medical expenditures, potentially resulting in higher medical expenditures if, for example, the illness reaches a more advanced stage (for example, Beck, 1974, 1980; Roemer *et al*., 1975; Evans, 1993). As well, it is often argued that, due to consumers' ignorance, physicians (suppliers) are able to induce demand. For these reasons, they argue, publicly funded health care and government intervention in the health market are necessary. However, the hypothesis that suppliers of medical care control the demand for health care is a controversial topic in the literature about health economics (Ferguson, 1994; Rice and Labelle, 1989) and uncertainty and risk are not unique to the health care market.

It can and has been argued that the health care market is different from other markets because of the severity of market failures: uncertainty of incidence of illness, economies of scale, insufficient information for rate making, and moral hazard. For the discussion of public policy, however, "market failure" should be used to describe instances in which the government can improve welfare in a way that the market cannot. The mere existence of problems with the market is not reason enough to support government intervention, especially given that there has been documentation of government failures that are as serious as market failures: poor public accountability, information asymmetry, abuse of monopoly power, and failure to provide public goods. (For example, see Clemens *et al*., 2004; Tullock *et al*., 2002; Harding and Preker, 2000; Mitchell and Simmons, 1994.)

The Canada Health Act and health system reform

While the Canada Health Act's provisions attempt to solve problems to do with the absence of insurance, the act ignores the problem of moral

hazard. Consumers are not charged for using most health care services, and providers of medically necessary services either bill the government for the fees that are collectively negotiated with the government, or are provided with a global budget based on past service provision and other considerations. Market prices are not used to allocate resources.

A basic economic concept is that, everything else being equal, the quantity demanded of a good will rise as the price of that good falls. This "law of demand" applies to the market for health care as much as any other: if the price of health care to consumers is negligible, the demand for it will be high. It would be possible to spend the entire government budget on health care and still have unmet demand for many health services. It is not surprising, then, that the Canadian health system exhibits the symptoms of excessive demand: waiting lists, overcrowded emergency rooms, shortages of care providers, etc.

Thus, there is a role for market forces in health care even if we agree that all money comes from one source (yours by choice, or yours by taxation), that there should be a public system to ensure that quality care is available to everyone, and that no one is bankrupted by a medical crisis. As many royal commissions and government inquiries into the health care system have determined, the system needs better and more efficient management of resources (for example, see Romanow, 2002), but this will only happen if the benefits and costs of decisions can be measured. Market prices are the best method of doing this. A system without any financial connection between use and costs will never be able to allocate resources effectively.

Section 3: Alberta's Health Care System

There are many ways of organizing a health care system to achieve the goal of improving the health of the population. Despite many structural differences, most systems take into account three basic principles: affordability, broad access to care, and high quality care. This section provides an overview in numbers of how Alberta fares in these areas.

Cost

In 2002/2003, the Alberta government spent $6.8 billion, or a third (33.1 percent) of its total expenditure on health care. (These figures differ slightly from those in table 3.2, which reports Statistics Canada data.) The $6.8 billion represents an 8.2 percent increase over 2001/2002, an extra $1.4 million per day (Alberta Health and Wellness, 2003b).

Despite the health ministry's contention that "the 2002/2003 fiscal year represented the beginning of the transition to a sustainable health care system," (Alberta Health and Wellness, 2003b) health spending has been increasing over the last five years and is expected to consume 34 percent of provincial program spending in 2003/2004 (tables 3.1). Since 1995, health spending in Alberta has increased by more than 80 percent, four times faster than all other government spending (Alberta Health and Wellness, 2003c). Currently, the government spends the highest portion of its budget on health care, followed by education at 24.84 percent of total expenditures, social services (14.29 percent) and resource conservation and in-

Table 3.1: Alberta Health Spending as a Percentage of Provincial Program Spending

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04 (forecast)
Nominal Health Spending ($ millions)	4,516	5,118	5,890	6,431	6,771	7,431
Percentage of Provincial Program Spending (excludes debt charges)	31.5	31.1	30.7	29.7	33.5	34.0

Source: Statistics Canada, Public Institutions Division, 2003; calculations by authors.

dustrial development (12.51 percent), while all the other categories of spending account for 16.53 percent of spending (table 3.2).

The majority of health care funding in Alberta comes from general revenues (69.7 percent), with premiums accounting for 13.7 percent of revenues, and federal funding, in the form of the Canada Health and Social Transfer (now just the CHT, as concerns health care financing) for 13.6 percent (table 3.3). In total, the federal government covers about 16 percent of Alberta's health care costs and the province will receive an additional $250 million in the first year of a three-year commitment announced in the 2003 federal budget—this amount will pay to operate Alberta's health system for 13 days (Alberta Health and Wellness, 2003c).

Table 3.2: Allocation of Spending by the Alberta Government in 2002/03

	Spending ($ Millions)	Percent of Total Expenditures
General Government Services	313	1.47
Protection of Persons and Property	679	3.19
Transportation and Communication	528	2.48
Health (hospital care, medical care, preventive care, and other health services)	6,771	31.83
Social Services (social assistance, Workers' Compensation benefits, employee pension plan benefits, veterans' benefits, motor vehicle accident compensation, and other social services)	3,039	14.29
Education (elementary, secondary, and post-secondary education, special retraining services, and other education)	5,285	24.84
Resource Conservation and Industrial Development	2,661	12.51
Environment	160	0.75
Recreation and Culture	318	1.49
Labour, Employment, and Immigration	62	0.29
Housing	111	0.52
Regional Planning and Development	30	0.14
Research Establishments	153	0.72
General Purpose Transfers to Other Government Subsectors	89	0.42
Debt Charges	1,073	5.04
Other Expenditures	0	0.00
Total	21,274	100.00

Note: Categories may not sum to 100 percent due to rounding.
Source: Statistics Canada, Public Institutions Division, 2003.

Table 3.3: Sources of Provincial Health Funding in Alberta, 2002/2003

	Major Categories ($ millions)	2002/2003 % of Total Health Funding Sources
Contribution from General Revenue Fund	$4,768	69.7
Canada Health and Social Transfer	$931	13.6
Premiums	$937	13.7
Lottery Funding	$108	1.6
Other Revenue	$38	0.5
Third Party Recoveries	$59	0.9
Total	6,841	100

Source: Alberta Health and Wellness, 2003b.

Table 3.4: Health Expenditure by Use of Funds in Alberta, 2003 (forecast) (Total Public and Private Spending on Health Care)

	Expenditures ($ millions)	Percent of Total
Hospitals	3,748.3	29.6
Other Institutions	833.6	6.6
Physicians	1,520.2	12.0
Other Professionals	1,622.5	12.8
Drugs	1,759.8	13.9
Capital	671.1	5.3
Public Health and Administration	1,258.6	10.0
Other Health Spending (includes such expenditures as home care, ambulances, prostheses, research)	1,233.8	9.8
Total	12,647.9	100.0

Source: Canadian Institute for Health Information, 2003d.

As in the rest of Canada, the private sector is an important funder of the health care system in Alberta, accounting for 28.5 percent of health care spending in the province (table 3.6). Adding this amount to what the public sector finances brings total health spending in Alberta to more than $12.6 billion (table 3.4).

Given the Canada Health Act, it is not surprising that the majority of hospital funding comes from the government (93.2 percent) and that it pays close to 100 percent of physician costs (tables 3.5 and 3.6). In only two categories does private financing comprise the majority expenditure: other professionals (chiropractors, naturopaths, and other practitioners) and drugs. In these two categories, private financing accounts for 89.2 percent and 63.5 percent, respectively.

Table 3.5: Health Expenditure by Use of Funds in Alberta, 2003 (forecast) ($ millions)

	Public[1]	Private	Total
Hospitals	3,495.1	253.2	3,748.3
Other Institutions	641.1	192.6	833.6
Physicians	1,488.8	31.4	1,520.2
Other Professionals	174.8	1,447.7	1,622.5
Drugs	643.2	1,116.6	1,759.8
Capital	571.2	99.9	671.1
Public Health and Administration	1,258.6	0.0	1,258.6
Other Health Spending (includes such expenditures as home care, ambulances, prostheses, research)	771.7	462.1	1,233.8
Total	9,044.4	3,603.5	12,647.9

[1]Public health expenditure includes all expenditures by the provincial government as well as direct health expenditures by the federal government, municipal governments, and by other provincial programs (Workers' Compensation Board, Quebec Drug Insurance Fund, etc.).
Source: Canadian Institute for Health Information, 2003d.

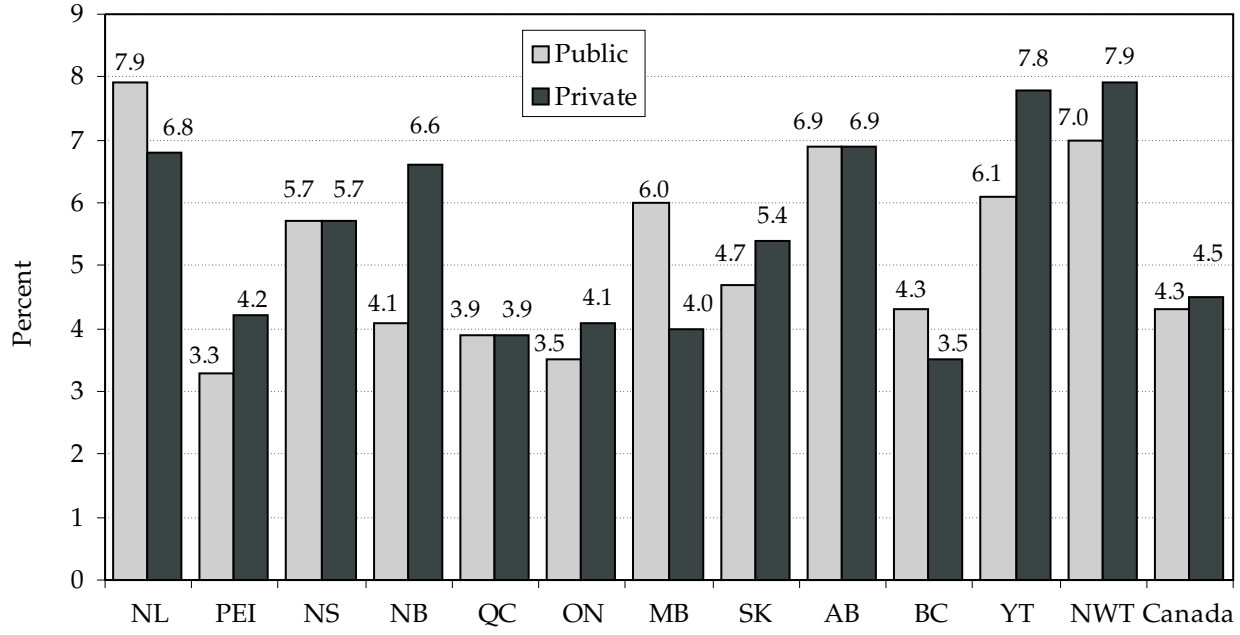
Table 3.6: Health Expenditure by Use of Funds in Alberta and Canada, 2003 (forecast)—Percent of Public and Private Spending on Health Care

	Alberta		Canada	
	Public[1]	Private	Public[1]	Private
Hospitals	93.2	6.8	92.0	8.0
Other Institutions	76.9	23.1	72.7	27.3
Physicians	97.9	2.1	98.9	1.1
Other Professionals	10.8	89.2	8.7	91.3
Drugs	36.5	63.5	38.5	61.5
Capital	85.1	14.9	78.4	21.6
Public Health and Administration	100.0	0.0	100.0	0.0
Other Health Spending (includes such expenditures as home care, ambulances, prostheses, research)	62.5	37.5	62.0	38.0
Total	71.5	28.5	69.9	30.1

[1]Public health expenditure includes all expenditures by the provincial government as well as direct health expenditures by the federal government, municipal governments, and by other provincial programs (Workers' Compensation Board, Quebec Drug Insurance Fund, etc.).
Source: Canadian Institute for Health Information, 2003d; calculations by authors.

From 1996 to 2001, of the provinces, Alberta had the second largest increase in per capita public spending on health (after Newfoundland) and the largest increase in private spending per capita (figure 3.1). Nonetheless, as table 3.7 shows, public health spending in Alberta in 2003 was $2,867.84 per capita, which is more than the Canadian average ($2,681.72) and which ranks fifth

Figure 3.1: Real Average Annual Rates of Growth of Public and Private Expenditures per Capita, by Province/Territory and Canada, 1996 to 2001



Source: Canadian Institute for Health Information, 2003, p. 39.

Table 3.7: Per Capita Health Expenditure, 2003 (forecast)

	Public[1] ($)	Private ($)	Total ($)
Newfoundland and Labrador	3,017.78	821.06	3,838.84
Prince Edward Island	2,706.15	1,202.80	3,908.95
Nova Scotia	2,610.99	1,109.74	3,720.74
New Brunswick	2,613.33	1,101.86	3,715.19
Quebec	2,477.30	999.27	3,476.57
Ontario	2,596.98	1,348.34	3,945.31
Manitoba	3,162.15	1,058.12	4,220.27
Saskatchewan	2,917.48	959.18	3,876.66
Alberta	2,867.84	1,142.62	4,010.46
British Columbia	2,879.43	1,039.76	3,919.19
Yukon Territory	3,958.45	1,043.22	5,001.67
Northwest Territories	6,751.70	624.45	7,376.15
Nunavut	5,991.16	325.01	6,316.17
Canada	2,681.72	1,157.42	3,839.14

[1]Public health expenditure includes all expenditures by the provincial government as well as direct health expenditures by the federal government, municipal governments, and by other provincial programs (Workers' Compensation Board, Quebec Drug Insurance Fund, etc.).
Source: Canadian Institute for Health Information, 2003d.

highest after Manitoba ($3,162.15), Newfoundland and Labrador ($3,017.78), Saskatchewan ($2,917.48), and British Columbia ($2,879.43). Per capita private health care expenditures in Alberta, at $1,142.62, are lower than the national average ($1,157.42), with the province ranking third in private spending among the provinces. However, in terms of total health spending, Alberta's ($4,010.46) is above the national average ($3,839.14), with the second highest per capita expenditures of the provinces.

Table 3.8: Age- and Sex-Adjusted Provincial Government Health Expenditures Per Capita by Province in 2001, Ranked Highest to Lowest

Newfoundland and Labrador	$2,576
Alberta	$2,498
British Columbia	$2,399
Manitoba	$2,330
Ontario	$2,128
Saskatchewan	$2,087
New Brunswick	$2,049
Quebec	$2,023
Prince Edward Island	$1,982
Nova Scotia	$1,908
Canadian average	$2,187

Source: Canadian Institute for Health Information, 2003d.

This scenario changes when demographic differences between the provinces are taken into account. Using 2001 data, the Canadian Institute for Health Information (CIHI) calculated provincial government spending adjusted for provincial differences in demographics. Alberta's population is, on average, younger than that of most other provinces—only 10.4 percent of the population is over the age of 65 compared to 13 percent for Canada as a whole (Statistics Canada, 2002e). Therefore, in the age- and sex-adjusted ranking of public sector spending on health care (table 3.8), Alberta rises from fourth to second spot, after Newfoundland and Labrador (Canadian Institute for Health Information, 2003a).

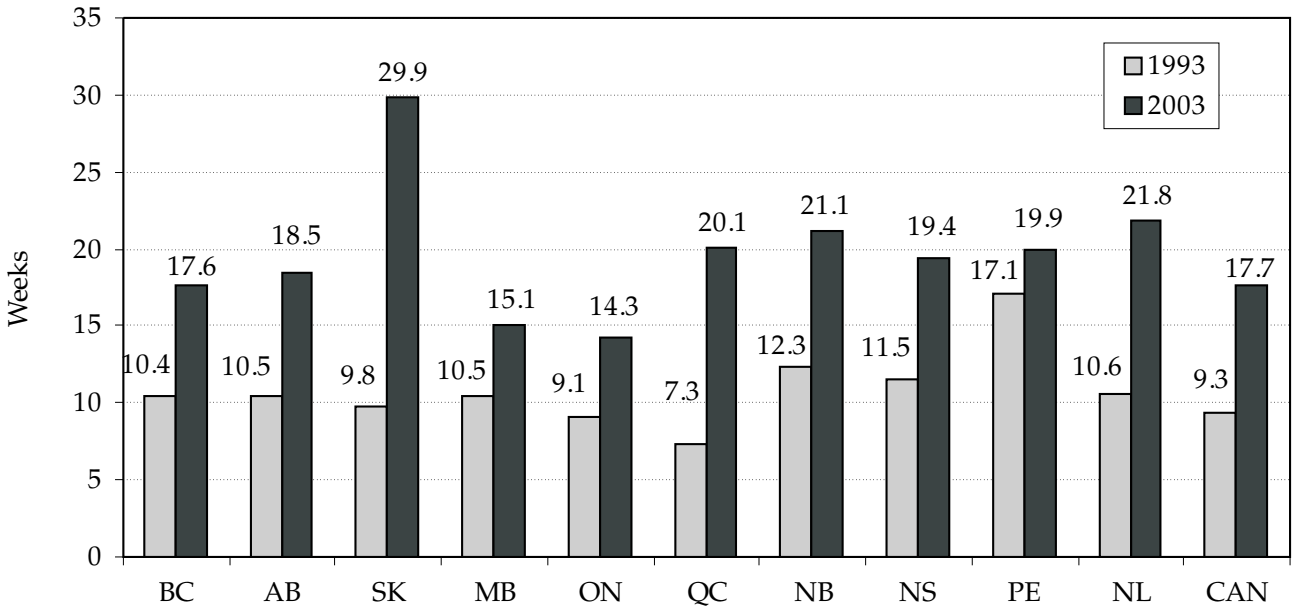
Access

Statistics Canada's *Access to Health Care Services in Canada, 2001* examines access to health care services in Canada, including 24-hour, 7-day-a-week access to first-contact services and specialized services, highlighting barriers to care and waiting times. In the survey, a lower percentage of the Alberta population (15 and over) reported that they had a regular family physician than the national average, 84.1 percent versus 87.7 percent. Further, a slightly lower percent of the Alberta population (91.2 percent) rated the care they received from their family physician as good or excellent than the Canadian average (92.2 percent), and slightly more Alberta residents said that they had unmet health needs, 11.4 percent versus Canada's 11 percent.

Looking at the distribution of waiting times, *Access to Health Care* found that 89.5 percent of Alberta respondents who had waited for specialist services reported wait times for specialist visits of three months or less (the Canadian average was 88.3 percent). Approximately 85.2 percent of the waits for non-emergency surgeries in Alberta were three months or less compared to the Canadian average of 80.8 percent (data for this category are to be interpreted with caution for Alberta because of high sampling variability). Finally, the percent of wait times for diagnostic tests that fell into the three months or less category was 91.6 percent for Alberta and 90.8 percent for Canada.

Waiting Your Turn: Hospital Waiting Lists in Canada, published by The Fraser Institute, is still the only comprehensive, nationwide measure of waiting lists in Canada. Published since 1991, *Waiting Your Turn* surveys specialist physicians across the country about their average waiting times for a number of elective procedures, with the exception of cardiovascular surgery where emergent, urgent, and elective waits are mea-

Figure 3.2: Median Wait between Referral by GP and Treatment, by Province, 1993 and 2003



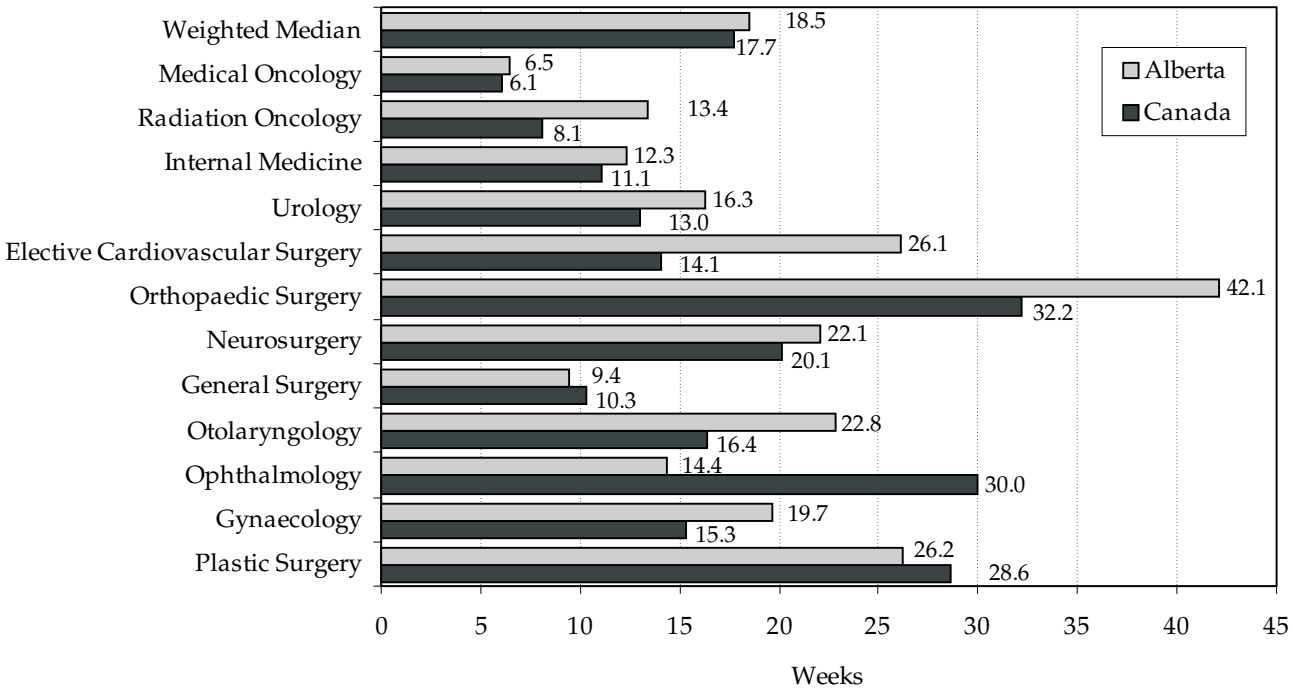
Source: Esmail and Walker, 2003.

sured. Among the specialists questioned are general surgeons, orthopaedic surgeons, ophthalmologists, oncologists, cardiovascular surgeons and six other specialties. Among the included procedures are coronary artery bypass, radiotherapy, hip and knee replacements, cataract removal, and many others. *Waiting Your Turn* measures a wait in two parts: from the time a general practitioner (GP) refers a patient to a specialist and the patient receives an appointment with the specialist, and from the specialist visit to the patient's receipt of treatment for their condition.

Alberta has relatively long waiting times compared to other provinces for the GP-to-specialist portion of the wait measured: patients in Alberta experienced waits of 10.0 weeks in 2003 compared to a national average of 8.3. However, for treatment after having seen a specialist, Alberta residents have the third shortest waits in Canada, at 8.5 weeks in 2003 versus the best performing province, Ontario, in which residents wait 7.1 weeks for treatment. The Canadian average was 9.5 weeks from specialist to treatment. As a result, Alberta has the fourth shortest total waits for treatment from GP referral, at 18.5 weeks: Ontario (14.3 weeks), Manitoba (15.1 weeks), and British Columbia (17.6 weeks) all outperform Alberta on the total waiting time measure.

As well, Alberta's waiting times are increasing, albeit not as much as those for the country as a whole. From 1993 to 2003, the wait from GP to specialist went from 3.6 weeks to the 10.0 weeks reported for 2003, and the specialist-to-treatment wait went from 6.9 weeks to 8.5 weeks. This marks a 76.2 percent increase in total wait times, from GP to treatment (figure 3.2). The wait time for Canada increased 90.3 percent during this time period.

Figure 3.3: Median Total Expected Wait between Referral by GP and Treatment, by Specialty, Alberta and Canada, 2003



Source: Esmail and Walker, 2003.

Table 3.9: Computerized Tomography (CT) Scanners and Magnetic Resonance Imagers (MRIs) Per Million Population

	Alberta (2003)	Canadian average (2003)	OECD average (2001)[1]
CT Scanners	9.6	10.3	16.9
MRIs	7.3	4.7	6.3

[1]The Organisation for Economic Co-operation and Development (OECD) average includes only those countries with universal access to health care systems. The United States and Mexico do not have universal access health care systems, and thus have not been included for comparison in this document.
Sources: OECD, 2003; Canadian Institute for Health Information, 2003c.

According to *Waiting Your Turn*, Alberta has much shorter wait times from GP to treatment than the national average for ophthalmology (14.4 weeks vs. 30.0 for Canada), while its trouble spots—areas in which the province has waiting times that are more than five weeks longer than the national average—include otolaryngology, orthopaedic surgery, elective cardiovascular surgery, and radiation oncology (figure 3.3).

With respect to the availability of diagnostic tools such as magnetic resonance imagers (MRIs), Alberta compares favorably to the Canadian average, while Canada, including Alberta, fares poorly relative to other industrialized countries (table 3.9). Alberta has 23 operational MRIs and 30 computerized tomography (CT) scanners (Canadian Institute for Health Information, 2003c). A comparison of provincial access to health technology shows that Alberta ranks ninth of 10 provinces for access to CT scanners and first of nine provinces for access to MRI machines (table 3.10).

The Alberta Ministry of Health and Wellness considers as key performance measures the wait lists/times for MRIs, joint replacement, heart surgery, cancer therapy, and long-term care. The ministry has developed a process for quarterly reporting on the waits for these procedures, as well as performance targets: an average wait of four months for hip or knee replacements; an average wait of one to six weeks for heart surgery/ angioplasty, depending on urgency; four weeks for radiation ther-

Table 3.10: Population Per Unit, Canadian Provinces, 2003

	CT Scanners			MRI		
	# of Units	Rate Per Million Population	Rank	# of Units	Rate Per Million Population	Rank
NL	11	20.7	1	1	1.9	9
PE	2	14.2	3	—	—	—
NS	15	15.9	2	4	4.2	5
NB	9	11.9	6	5	6.6	2
QC	94	12.6	4	40	5.5	3
ON	95	7.8	10	50	4.1	6
MB	14	12.2	5	3	2.6	8
SK	10	9.9	8	3	3.0	7
AB	30	9.6	9	23	7.3	1
BC	44	10.6	7	18	4.3	4
Canada	326	10.3	—	147	4.7	—

Source: Canadian Institute for Health Information, 2003c.

Table 3.11: Age Standardized Hospitalization Rates per 100,000 Provincial Residents, 2001/2002, Ranked Highest to Lowest

	Rate	% Change from 1995/1996
New Brunswick	12,573	-16.0
Saskatchewan	11,732	-20.7
Prince Edward Island	11,015	-17.7
Manitoba	10,175	-14.9
Newfoundland and Labrador	10,071	-20.9
Alberta	9,823	-14.6
Nova Scotia	9,273	-22.5
Quebec	8,411	-18.5
Ontario	8,222	-20.5
British Columbia	8,201	-22.8
Canadian average	8,796	-19.6

Source: Canadian Institute for Health Information, 2004a.

Table 3.12: Average Length of Hospital Stay (in days), 2001/2002, Ranked Highest to Lowest

	Days	% Change from 1995/1996
Manitoba	9.2	-1.1
Quebec	8.4	-6.7
Nova Scotia	8.2	12.3
Prince Edward Island	8.1	6.6
Newfoundland and Labrador	7.7	1.3
British Columbia	7.2	12.5
New Brunswick	7.2	7.5
Alberta	6.9	19.0
Ontario	6.5	-1.5
Saskatchewan	6.0	-11.8
Canadian average	7.3	1.4

Source: Canadian Institute for Health Information, 2004a.

apy; and decreases in the wait times for MRIs and admission to long-term care facilities (Alberta Health and Wellness, 2003b).

According to the ministry's 2002/2003 annual report, the number of persons waiting for hip or knee replacement surgery increased slowly from 2001 to 2003, while the average waiting time estimate remained at about five months, one month longer than the target. Average wait times for urgent inpatient heart surgery were on target, but the waits for urgent outpatient and planned outpatient heart surgery were well above their respective targets of two and six weeks. At the end of 2003, urgent outpatients in the Calgary region were waiting 17.9 weeks on average for heart surgery, while Capital region (Edmonton) patients were waiting 21 weeks; planned outpatients were waiting an average of 18 weeks in the Calgary region and 22.1 weeks in the Capital region. Average wait times for cancer radiation therapy also remained above target for the 2001-2003 period, at 8 to 11.5 weeks for breast cancer and 6.5 to 7.5 weeks for prostate cancer. As well, despite the relative abundance of MRIs in Alberta, the number of people waiting for MRIs almost doubled in the province between 2001 and 2003 (from 8,432 people to 16,149), while the number of scans performed remained constant. Finally, the number of people waiting for placement in long-term care facilities did not vary much from 2001/2002 to 2002/2003 and there is no evidence of a decreasing trend.

Alberta residents use hospitals more than other Canadians: at a rate 12 percent higher than the national average (table 3.11). Alberta's rate of decline from 1995/1996 was also third lowest among the provinces and below the national average. However, Albertans spent 5.5 percent fewer days as hospital inpatients than did other Canadians on average in 2001/2002 (table 3.12).

Table 3.13: Number of Physicians per 100,000 Population by Physician Type, 2002

	Family Medicine		Specialists	
	2002	% Change from 1998	2002	% Change from 1998
Newfoundland	110	6.8	65	-3.0
Prince Edward Island	85	16.4	51	-7.3
Nova Scotia	107	5.9	99	5.3
New Brunswick	93	3.3	64	1.6
Quebec	106	1.0	106	0.0
Ontario	85	-1.2	95	2.2
Manitoba	93	4.5	87	-1.1
Saskatchewan	96	10.3	59	-4.8
Alberta	97	12.8	84	9.1
British Columbia	109	2.8	89	2.3
Canada	96	2.1	93	2.2

Source: Canadian Institute for Health Information, 2004a.

Looking at the number of physicians per 100,000, which is a common way to compare the supply of physicians across jurisdictions, Alberta has seen more than average growth since 1998 (table 3.13). A 12.8 percent increase in family doctors per 100,000 population and a 9.1 percent increase in specialists per 100,000 population is impressive given the national averages of 2.1 percent and 2.2 percent, respectively. However, Alberta has fewer specialists as a proportion of its population than the national average and almost equals the national average for family doctors.

As well, both Canada and Alberta rate poorly compared to other countries in terms of physicians per 1,000 population. According to Organisation for Economic Co-operation and Development (OECD) data,[1] Canada's 2.1 doctors per 1,000 population put the country at seventeenth of 23 countries in 2001; Austria ranked first with 3.3 doctors per 1,000 population, and Turkey last with 1.3 (OECD, 2003). Alberta's rate of 1.8 doctors per 1,000 population in 2002 (extrapolated from table 3.13) would have put it at 20th in the OECD ranking, tied with Spain, ahead of only New Zealand, the Netherlands, and Turkey.

As in other provinces, the medical expertise in Alberta gravitates to the urban regions. In 1998/99, the number of specialists per 100,000 population was 125 in Edmonton, 105 in Calgary, and 77 for the province as a whole. Unlike specialists, family physicians were more evenly distributed throughout the province: the number of physicians per 100,000 was 104 in Edmonton, 88 in Calgary, and 86 for the province (Canadian Institute for Health Information, 2004a).

Alberta seems to be managing to retain its physicians. In 2002, 40 physicians moved abroad from the province and 39 returned, for a net loss of only one physician. In Canada that year, 500 physicians left and 291 returned, for a net loss of 209. This compares to a net loss of 275 physicians in Canada in 2001, and of 22 physicians in Al-

1 The United States and Mexico do not have universal access health care systems, and thus have not been included for comparison in this document.

Table 3.14: Number of Registered Nurses per 10,000 Population, 2001

	2001	% Change from 1997
Newfoundland	102.0	7.7
Prince Edward Island	91.4	-2.4
Nova Scotia	90.7	-1.2
New Brunswick	97.6	0.3
Quebec	78.8	-2.6
Ontario	67.6	-2.0
Manitoba	89.3	-3.1
Saskatchewan	80.8	-2.2
Alberta	74.5	0.5
British Columbia	66.7	-5.0
Canada	74.3	-2.2

Source: Canadian Institute for Health Information, 2004a.

berta (Canadian Institute for Health Information, 2004a).

The number of registered nurses (RNs) per 10,000 population saw little change in Alberta, while it fell in most parts of Canada between 1997 and 2001 (table 3.14). And, while Alberta has the third lowest number of RNs per 10,000 population (after British Columbia and Ontario), it experienced an increase in 2002, to 74.7 RNs per 10,000 people that year.

Some of Alberta's increase in RNs is at the expense of other provinces. According to the Saskatchewan Registered Nurses' Association (SRNA), the total number of practising nurses in Saskatchewan decreased by nine percent from 1990 to 2001—the association's data show that half of the nurses leaving Saskatchewan head to Alberta (Esmail and Ramsay, 2003). A national study of RN workforce trends show that British Columbia (29.2 percent), Alberta (22.8 percent) and Ontario (21.5 percent) attract the most graduates of Canadian nursing programs who have moved since graduation (Canadian Institute for Health Information, 2003e). The study postulates that the popularity of these provinces reflects not only their large populations, but may be the result of more people from BC, Alberta, and Ontario being likely to attend school out-of-province before returning home to work. The prominence of these three provinces as a choice destination for RN graduates may also indicate preferred lifestyle, better job availability, or more lucrative career opportunities in these provinces. It should be noted, however, that both BC and Ontario experienced decreases in the number of RNs per 10,000 people from 2000 to 2002, while Alberta's proportion increased (Canadian Institute for Health Information, 2003e).

Another point of interest is that Alberta is projected to lose nine percent of its RN workforce to retirement between 2002 and 2006.[2] This compares favourably with other provinces, as BC is expected to lose 14 percent, Manitoba and Saskatchewan 11 percent, and Canada as a whole 13 percent (Canadian Institute for Health Information, 2003e).

Quality

One of the many measures of health system quality is public satisfaction. Alberta Health and Wellness has targets for ease of access to health services and for the quality of services received. The ministry met its target for access in 2003—86 percent of Albertans reported easy access to physician services and 72 percent had little difficulty accessing hospital services. The ministry also performed well in terms of patients' ratings of the quality of care they received overall and in a hospital setting, with 85 percent and 83 percent of pa-

2 This is calculated as the expected loss of RNs in nursing aged 50 to 65 from 2002-2006 as a percentage of the 2001 provincial workforce.

Table 3.15: The Key Strengths and Opportunities for Improvement in the Alberta Health Care System According to a 2003 Survey of more than 4,000 Albertans

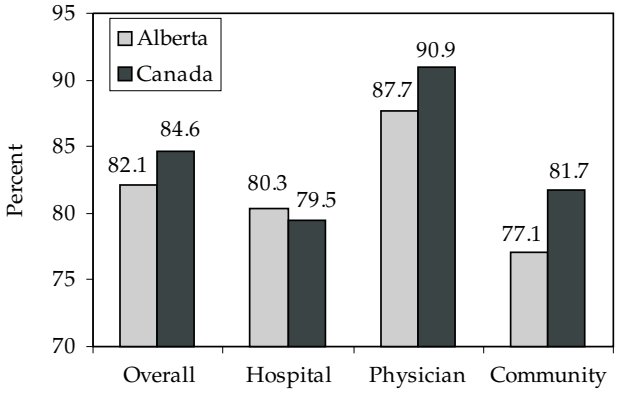
Key Strengths	Key Areas for Improvement
Access to and satisfaction with general practitioner services (monitor access as population and GP supply change)	Access to and satisfaction with emergency room services
Access to and satisfaction with lab tests	Access to and satisfaction with alternative forms of primary care services in the community when the services of a personal family doctor are not available
Satisfaction with surgical services	Access to specialists
Satisfaction with special therapy services	Understanding and reducing the level of concern about patient safety
Satisfaction with diagnostic imaging	Occurrence of, and addressing of complaints

Source: Health Services Utilization and Outcomes Commission, 2003b.

tients satisfied in 2003. While some other measures fell just shy of the ministry's targets, the main area for improvement was the 33 percent of patients in 2002 who were satisfied with the response they received to a complaint about health services—the ministry goal is 50 percent (Alberta Health and Wellness, 2004c).

While these measures seem to indicate that Albertans are relatively happy with their health care system, these survey results are more favourable than those of the 2003 survey conducted by the Ipsos-Reid Corp. for the Health Services Utilization and Outcomes Commission (HSUOC, 2003b). In this survey, only 42 percent of Alberta patients reported that it was easy or very easy to gain access to the system, and 74 percent of people who had received care found it to be of good, very good, or excellent quality. Table 3.15 summarizes what the survey found to be the system's strengths and areas for improvement. To some extent, they mirror the results of the ministry of health's survey in that Albertans seem generally satisfied with access to most of the health system, with the exceptions of emergency room services and specialists, as well as the quality of care for people who do not have a regular family doctor. Ipsos-Reid also found Albertans to be unhappy with the way in which their complaints are handled.

Figure 3.4: Percent of Alberta Patients Age 15 and Over who Rated Themselves as either Very or Somewhat Satisfied with Health Services, by Type, 2000/2001



Source: Alberta Health and Wellness, 2002c.

Relative to the rest of Canada, Alberta fares slightly worse on public ratings of satisfaction with the overall system, physician, and community care, while performing better with respect to hospital care (figure 3.4).

Self-reported health status is a general indicator of the overall health status of individuals. The percentage of Albertans who, in 2000, considered themselves to be in very good or excellent health was in the low 60s; for younger age groups Alber-

Table 3.16: Mortality Rates, Canadian Average versus Alberta

	Alberta	Canada
Number of deaths per 100,000 people from all types of cancer (1997)	170.5	184.1
Number of deaths per 100,000 people from ischaemic heart disease (1997)	125.4	131.6
Infant mortality rate per 1,000 live births (1999)	5.8	5.3

Source: Statistics Canada, 2002d; Statistics Canada, 2003.

tans reported slightly lower health status than Canadians, and there is no difference for the older age groups (Alberta Health and Wellness, 2002c). The province's target for this area is 70 percent of Albertans reporting very good or excellent health (Calgary Health Region, 2003).

In terms of health status measures, life expectancy at birth in Alberta was 79.2 years in 1999, which is slightly more than the Canadian average (79 years), and life expectancy at age 65 was 18.8 years in 1999, again slightly more than the national average of 18.5 years (Statistics Canada, 2002f). Alberta's disability-free life expectancy is slightly less than the Canadian average: it was 68.0 years in 1996 compared to the Canadian expectancy of 68.6 years (Statistics Canada, 2002c).

Table 3.16 shows how Alberta's mortality rates compare to the Canadian average. While Alberta has fewer deaths per 100,000 people from all types of cancer and from ischaemic heart disease (also known as coronary artery disease) than the Canadian average, the province has a higher infant mortality rate (5.8 deaths per 1,000 live births) than the Canadian average of 5.3 deaths per 1,000 live births. The province's target in 2003 was for an infant mortality rate of 5.0 deaths per 1,000 live births (Calgary Health Region, 2003).

Because chronic diseases are the leading causes of death in Alberta, the government has set several targets to 2012 and strategies to try to reduce the rates of cancer, heart disease, suicide, measles and other preventable illnesses, and mortality in general. For example, *Framework for a Healthy Alberta* (2004d) sets a goal of increasing the percent of women aged 50 to 69 who are screened for breast cancer from 71 percent to 80 percent. Another objective is to decrease the mortality rate from all types of heart disease from 175 to 140 per 100,000 people. The targets are very specific and there are government strategies listed—such as implementing screening programs and promoting healthy eating and tobacco reduction—that are intended to reach those goals.

Table 3.17 indicates the number of hip fractures per 100,000 population and the proportion of women giving birth by caesarean section (C-section). Hip fractures occur for various reasons, including the prescription of potentially inappropriate psychotropic medications to the elderly and safety concerns in long-term care facilities (Canadian Institute for Health Information, 2004b). It could be considered a proxy for the appropriateness of the care being provided, as is the proportion of women delivering babies by caesarean section (which is often considered "unnecessary" surgery). While Alberta's C-section rate (21.1 per 100,000 population) is slightly less than the national average (21.4), its age-standardized rate of hip fractures for seniors (65 and older) is higher than that of Canada as a whole, Manitoba, Nova Scotia, Newfoundland and Labrador, Quebec, and New Brunswick (table 3.17). With respect to the appropriateness of care in Alberta, the results are mixed.

Table 3.17: Measures of Appropriateness of Health Care Provided, 2000/2001

	Age-Standardized Rate of Hip Fractures per 100,000 Population Age 65 and older	Women Delivering Babies in Acute Care Hospitals by Caesarean Section per 100,000
Newfoundland	559	25.5
Prince Edward Island	610	24.8
Nova Scotia	566	23.5
New Brunswick	455	26.0
Quebec	511	18.7
Ontario	605	21.9
Manitoba	567	18.7
Saskatchewan	608	18.4
Alberta	592	21.1
British Columbia	610	24.7
Canada	575	21.4

Source: Canadian Institute for Health Information, 2004b.

The data presented in table 3.18 indicate a middle-of-the-road or relatively poor performance for Alberta in terms of the effectiveness of the health care system. Alberta's rate of pneumonia and influenza hospitalizations for seniors is also in the middle—fifth worst or sixth best—although the rate is above the Canadian average (table 3.18). And, although readmission for medical conditions may involve external factors that a hospital cannot control, high readmission rates should be a signal for hospitals to reassess their practices: are they discharging patients too early; what is their relationship with community-based care? (Canadian Institute for Health Information, 2004b). Table 3.18 shows that Alberta's hysterectomy readmission rate (0.9 percent) is higher than the national rate of 0.8 percent (without Quebec and Manitoba, where data are unavailable due to differences in data collection). Its readmission rate for prostatectomies is much lower, at 1.4 versus 2.1 per 100,000 for Canada (without Quebec and Manitoba).

As well, while not all admissions for ambulatory-care-sensitive conditions (hospital admissions that could have been avoided through appropriate ambulatory care) are avoidable and the "right" level of use is not known, a high rate in this measure is thought to reflect problems in obtaining access to primary care (Canadian Institute for Health Information, 2004b). With a ratio of 460 per 100,000 population, Alberta ranks fifth, well above the Canadian provincial average of 370 per 100,000 population (table 3.18).

However, compared to other regions in Canada, Alberta had much lower readmission rates between 1998 and 2000 for heart attacks (5.3 percent for Alberta, and 3.4 and 2.4 percent respectively for the Calgary Health Region and Capital Health (i.e., Edmonton region) compared to a national average of 6.7 percent[3]) (Canadian Institute for Health Information, 2004b). Alberta also had in-hospital mortality rates following a heart attack (within 30 days of an initial hospitalization for a heart attack) between 1998 and 2000 that were substantially below the national average[4] of 12.1 percent (Calgary Health Region had a rate of 9.1 percent, Capital Health of 9.4 percent, and Alberta as a whole of 9.9 percent), and a lower than the national average rate[5] (18.9 percent) of in-hospital mortality within 30 days of an initial hospitalization for a stroke (Calgary Health Region had

3 The national average for unplanned heart attack readmissions does not include rates for Newfoundland and Labrador, Quebec, and Manitoba for which data are unavailable due to differences in data collection.

4 The national average for 30-day AMI (heart attack) in-hospital mortality rate does not include rates for Newfoundland, British Columbia, and Quebec for which data are unavailable due to differences in data collection.

Table 3.18: Measures of the Effectiveness of the Health Care System, 2000/2001

	Pneumonia and Influenza Hospitalization per 100,000 Population Age 65 and older	Hysterectomy Readmission Rate (percent)	Prostatectomy Readmission Rate (percent)	Age-Standardized Inpatient Acute Care Hospital rate for Conditions Where Appropriate Ambulatory Care Prevents or Reduces the Need for Hospital Admissions (per 100,000 Population)
Newfoundland	1,114	0.9	2.8	486
Prince Edward Island	1,396	1.2	—	1,101
Nova Scotia	1,328	0.9	2.5	375
New Brunswick	1,550	0.8	2.6	576
Quebec	997	—	—	335
Ontario	1,044	0.7	2.0	311
Manitoba	1,219	—	—	462
Saskatchewan	1,468	1.1	2.5	554
Alberta	1,292	0.9	1.4	460
British Columbia	961	0.9	2.1	385
Canada	1,092	0.8*	2.1*	370

*Note: National averages for readmissions do not include Quebec or Manitoba.
Source: Canadian Institute for Health Information, 2004b.

a rate of 15.9 percent, Capital Health of 14.7 percent, and Alberta as a whole of 16.2 percent) (Canadian Institute for Health Information, 2004b). The readmission rates for asthma were roughly equivalent to the national average (5.9 percent)[6] in Alberta, the Calgary Health Region, and Capital Health (Canadian Institute for Health Information, 2004b).

In terms of efficiency, Alberta performs relatively well compared to the other provinces (table 3.19). It has the third lowest percentage of patients hospitalized for conditions that experts say can often be treated on an outpatient basis, such as nasal procedures, hypertension, sprains and minor injuries, and anxiety disorders. As well, the average number of actual days stay was shorter than expected.

Conclusion

Alberta is one of the biggest spenders per capita on health care in Canada, yet its health care system relative to other provinces is not exemplary. Access to care seems to be a concern—waiting times are an issue, from GP to specialist, and especially in the areas of orthopaedic and elective cardiovascular surgery. Yet the number of surgeries performed has been increasing, as have the number of physicians in the province. Even the proportion of registered nurses, while relatively low in Alberta, has been increasing.

While Albertans have longer life expectancies than many other Canadians, their self-reported health status ranks lower. There seems to be general satisfaction with the system, and the level of

5 The national average for 30-day stroke in-hospital mortality rate does not include rates for British Columbia and Quebec for which data are unavailable due to differences in data collection.

6 The national average for risk-adjusted, unplanned asthma readmissions does not include rates for Quebec and Manitoba for which data are unavailable due to differences in data collection.

Table 3.19: Measures of the Efficiency of the Health Care System, 2000/2001

	Percentage of patients hospitalized in acute care facilities for conditions or procedures that experts say often allow outpatient treatment not requiring admission (i.e., patients who may not require hospitalization)	The average number of actual days in acute care hospitals compared to expected length of stay (a positive value indicates actual days stay was longer than expected, and vice versa)
Newfoundland	9.6	0.86
Prince Edward Island	9.4	0.76
Nova Scotia	7.4	0.46
New Brunswick	9.1	0.46
Quebec	—	—
Ontario	5.9	-0.33
Manitoba	—	—
Saskatchewan	8.1	0.09
Alberta	7.3	-0.03
British Columbia	6.7	-0.06

Source: Canadian Institute for Health Information, 2004b.

public satisfaction more or less matches the government's targets, with the exception of how complaints are being processed. In this regard, it is impressive that the ministry of health and the regional health authorities have set specific targets for so many aspects of health status, system quality, etc., but it is disappointing that many of the targets are not being met and that the government strategies for improving the health of Albertans are more ambiguous than the targets they have set.

In terms of the appropriateness and effectiveness of the care provided, Alberta performs in the mid-range, while doing well in terms of efficiency compared to other provinces. Relative to OECD countries, however, Alberta ranks poorly in terms of access to health services and spending. Canada as a whole manages to outspend all but one other universal access health care system in the OECD, while its ranking for providing access to health services for the population is very low (Esmail and Walker, 2004). As well, while Canada fares well internationally with respect to health status measures, such as life expectancy and self-reported health, the country ranks low on health outcomes indicators, which include deaths from lung cancer, heart attack, and suicide (Conference Board of Canada, 2004). A middle-of-the-road performance and above-average spending within Canada, therefore, is not a situation that appears to serve Albertans' needs or provide value for money. In fact, no system in Canada meets these important goals.

What is clear from a review of its health care system is that Alberta has serious hurdles to overcome in providing access to health services. Measuring the extent of the problems and setting performances targets is a step in the right direction, but it is difficult to see how the government will be able to improve access and health outcomes without radically changing the system's current structure.

Section 4: Building a Better Health Care System

Among the highlights of the Alberta government's 2004 budget, was an announced increase in health spending of 8.4 percent, a cash infusion that puts the health budget at $8 billion in fiscal year 2004/2005. This means that health care consumes 38 percent of the total 2004/2005 government program budget. Future increases of 5.7 percent and 3.8 percent will bring ministry spending to almost $8.8 billion by 2006/2007 (Government of Alberta, 2004b).

"These increases are simply not sustainable," said Finance Minister Patricia Nelson. "The time for meaningful health reform is now" (Government of Alberta, 2004b). Two-and-a-half years ago, the Premier's Advisory Council on Health (chaired by Don Mazankowski) also concluded that Alberta's health care system wasn't sustainable:

> Spending on health is crowding out other important areas like education, infrastructure, social services, or security. If health spending trends don't change, by 2008 we could be spending half of the province's program budget on health. We do not believe that is acceptable. On top of that, demands for health care services are increasing and costs are going up. If there are new cures or new treatments, we want them all, even though having them all is driving up costs at a rate we simply can't afford (Premier's Advisory Council on Health, 2001).

The *Mazankowski Report* gave an extensive list of recommended reforms, all of which the government of Alberta accepted (Alberta Health and Wellness, 2004a). Yet, in the implementation process, a few of the suggestions that, in a Canadian context, could be called more radical—such as encouraging more choice and competition in the system—either have been subsequently rejected (eg., medical savings accounts) or only minimally implemented (eg., private surgical contracts). The general public, health care workers, and other groups in Alberta have been vocal in their resistance to any reforms that they perceive as violating the public administration and accessibility principles of the Canada Health Act. In the past, the Alberta government has also come into conflict with the federal government on issues of extra billing, delisting of services, and private health facilities (Henton, 2004a) To date, this atmosphere has limited the types of reforms the government has been able to accomplish.

The government's plan— *Alberta: Health First*

Alberta: Health First, Building a Better Public Health Care System is based on the 44 recommendations made by the Premier's Advisory Council in December 2001. As part of the plan, the government appointed the Alberta Health Reform Implementation Team to monitor the government's work on reforming the health system and to provide progress reports to Albertans. The team made its final report in January 2004. In it, the team consolidated the advisory council's recommendations under four main directions for reform: patient/customer focus, sustainability, accountability, and infrastructure support. While the report indicates that progress has been made in two of the four categories, there has been little done to ensure the sustainability of the system, and much of the work on improving accountability is still in progress.

1. **Patient/customer focus to help Albertans remain healthy and to provide quality service**.

Some of the highlights in this direction include the determination of 10-year health targets, the establishment of at least 10 primary health care projects, the province-wide expansion of the Health Link line, access standards for five health services (cardiac, major joint replacement, MRI/CT scans, breast and prostate cancer, and children's mental health services) as part of the Western Canada Wait List project, a waitlist registry on the worldwide web and study into ways to assist children living in poverty and provide educational support (Alberta Health and Wellness, 2004a).

2. **Sustainability to address health care funding, expenditures, and human resources.** In this area, the implementation team reports that many initiatives are being reviewed by the government, such as cooperating at the national level to set best practices for prescription drugs and the development of a new provincial plan for mental health services (Alberta Health and Wellness, 2004a).

   The government did not accept the recommendations of a task force on health care funding and revenue generation, which were presented in October 2002. The recommendations included changes to the provincial income tax system, the introduction of medical savings accounts and electronic health cards, and a further increase in health care premiums. They were rejected because the government "decided most Albertans would not accept" them (Government of Alberta, 2004a).

   Also submitted in October 2002 were the suggestions of a panel that reviewed the process by which the government determines which health services are publicly funded. In January 2004, the government agreed to maintain the currently funded categories of health services and, instead of creating a permanent advisory board on these issues, opted to reinforce the current method of reviewing new and emerging health services based on criteria proposed by the panel (Government of Alberta, 2004a). These criteria include safety, demonstrated benefits or effectiveness, impact on individuals and the health system, consistency with health reforms, and sustainability/financial implications of the new service (Expert Advisory Panel to Review Publicly Funded Health Services, 2003).

   The health ministry's 2004-2007 business plan outlines other concrete steps with regard to sustainability. These include the implementation of multi-year performance agreements with the health authorities that promote innovation, collaboration, and set out performance expectations and deliverables. The need for collaboration in the evaluation of alternative ways to finance programs not covered by the Canada Health Act is noted. As well, in the ministry's plan, increased flexibility of the health workforce and improved processes to evaluate the effectiveness and cost of new health technologies, including drugs, are deemed necessary for system sustainability (Alberta Health and Wellness, 2004c). However, the multi-year performance agreements and the changes to the health professions have yet to be completed (Alberta Health and Wellness, 2004a) and the extent of progress on the other fronts is not clearly articulated.

3. **Accountability to encourage better management of outcomes and make the best use of health providers.** The Health Services Utilization and Outcomes Commission issued the first report on how Albertans view the performance of their health care system. As of January 2004, more than 400 physicians were involved in compensation arrangements other than fee-for-service. These arrange-

ments include doctors who participate in primary care projects, those who provide specialized care, and academic physicians. The government has completed a recruitment and retention strategy for health care workers and is developing an action plan to have the appropriate number, mix, and distribution of health care personnel in the province. Finally, the government amended the Public Health Act to expand the scope of practice of nurse practitioners, and nine professions of 28 have come under the auspices of the 1999 Health Professions Act (Alberta Health and Wellness, 2004a). The act requires all health professional colleges (licensing bodies) to follow common rules to investigate complaints and set educational and practice standards for registered members. It also provides new definitions, requirements, and expectations for professionals' scopes of practice (Alberta Health and Wellness, 1999).

4. **Infrastructure support with an emphasis on government collaboration, information technology and research.** The government expected all Alberta regions, one third of doctors' offices, and half of all pharmacies in the province to be using electronic health records by spring 2004 and has developed a long-term investment strategy for information technology and province-wide data standards. Alberta is also involved in several collaborations, such as the Alberta Heritage Foundation for Medical Research and the Western Canada Wait List project (Alberta Health and Wellness, 2004a).

Will *Health First* work?

The vision statement of Alberta Health and Wellness is "Healthy and well Albertans." To attain this vision, the ministry has three core businesses, each of which comprises two goals. In its first core business, the ministry's goals are to encourage Albertans to choose healthier lifestyles and protect Albertans from communicable diseases and environmental health risks. In its second business, to ensure quality health services, the ministry works to improve access to health services and improve health service outcomes. Finally, in its business of leading the health system, the ministry focuses on the system's sustainability and organizational excellence within the ministry (Alberta Health and Wellness, 2004c).

Of the more than $7.3 billion that the health ministry expects to spend in 2003/2004, 3.2 percent will go toward encouraging and supporting healthy living, 95.3 percent toward providing quality health services, and 1.5 percent to leading the health system (Alberta Health and Wellness, 2004c).

Supporting healthy living

With respect to encouraging Albertans to choose healthier lifestyles, the ministry has set specific performance targets, implemented an extensive public education campaign, disseminated information on addiction, and worked with other ministries to address the needs of various at-risk communities. Given the Canada Health Act and the provincial government's rejection of the funding and revenue task force recommendations, there is little more that the ministry can do to encourage healthy behaviour—it cannot use cost-sharing mechanisms or increase premiums further to provide Albertans with more immediate incentives to live healthier lifestyles. There is, however, the possibility of changing the structure of health premiums in Alberta to create incentives for healthy behaviour.

Currently, premiums in Alberta total about $927 million, or 13.7 percent of health care costs in the province (Alberta Health and Wellness, 2003a). However, this percentage may not represent

enough of a cost to serve as a reminder to consumers that the costs of health services are significant. As an alternative to across-the-board increases in premiums, the province could consider risk-rated premiums, in addition to its education and information initiatives, to more effectively achieve a healthier population. These risk-rated premiums would replace a portion of the Alberta government's current, tax-based financing of health care. Therefore, rather than being a simple alternative form of financing, which does not provide any different incentive to the individual, these premiums would be paid on a risk-adjusted basis and reflect the scope of services covered.

The risk-adjustment would be tied to actions that individuals take to stay healthy (such as maintaining a lower weight) or behaviour that results in increased reliance on health services (such as smoking or heavy alcohol consumption). The risk-adjustment would not account for pre-existing conditions or family history, since these conditions are part of the reason that public or mandatory health insurance schemes exist. Low-income individuals and the chronically ill could be exempt from premium payments, and there could be subsidies for other groups. As well, the "sin taxes" that are associated with certain behaviours (such as taxes on liquor and cigarettes) would have to be discarded once the risk-adjusted premiums are levied, so as to avoid double-charging smokers and consumers of alcohol.

This concept, however, could have serious implications for the scope of state intervention in individuals' lives if the government is the only provider of insurance for medically necessary services. There would be the added cost of providing basic physical exams to consider versus the higher premiums collected from some residents and the lower premiums collected from others. As well, if a person "fails" their physical exam, they would have no alternative insurer to approach for less expensive premiums. As user fees, "sin taxes" may be the more efficient way to "penalize" or discourage behaviours that are costly to the health system.

There are also other options worth considering. The *Mazankowksi Report* noted that, very often, people know what they need to do to stay healthy but, for whatever reason, don't make the right choices:

> The right incentives can make a difference. Ideas such as medical savings accounts would not only give people more responsibility for how they use the health care system, but also could allow them to use their "savings" on a broader range of health promotion and wellness activities and programs. Ideas such as variable premium rates… could also provide an incentive for people to say healthy. Other approaches such as tax credits, tax reductions or credits against health premiums, or partial refunds of health premiums towards the cost of approved personal health promotion programs could also be considered (Premier's Advisory Council on Health, 2001).

One of the most important roles for a government to play in health care is in the area of public health and prevention activities. As discussed in section 2, there is evidence that public access to sanitation, safe water, immunization, screening services such as mammograms, and other preventive care have a positive effect on the health of a population (Conference Board of Canada, 2004; Ramsay, 2001; World Health Organization, 2000). Though the health ministry has set targets for childhood immunization rates, the proportion of seniors who receive an annual flu vaccine, suicide rates, injuries, and screening rates for breast cancer, it has yet to meet any of its 2004/2005 targets.

Currently, the Alberta government spends about 14 percent of its budget on public health and administration (see table 3.5 for dollar figures). Estimates put this share of expenditure at 9.3 percent of public sector health spending in Canada in 2003 (Canadian Institute for Health Information, 2003d). Because the category comprises two elements—public health and administration—it is impossible to determine whether Alberta spends more than other provinces on public health or if its system is more costly to administer. It is likely the latter case, given that Alberta health ministry forecasts put spending on the core business of supporting healthy living (which includes public health issues) at just under $239 million in 2003/2004, or 3.2 percent of total health spending (Alberta Health and Wellness, 2004c).

Ensuring quality health services

Despite estimates that the health system as a determinant of health accounts for only 25 percent of health status (Conference Board of Canada, 2004), the vast majority of ministry spending is directed to the core business of ensuring quality health services, which centres around physicians, multi-disciplinary teams, hospitals, long-term care, and other aspects of the health system.[7] The targets in this core business are concerned with waiting times, ease of access to physician and hospital services, patient satisfaction, success in treating people in their own communities (the ambulatory care sensitive conditions hospitalization rate, which is in table 3.18) and the heart attack survival rate (in hospital) (Alberta Health and Wellness, 2004c).

Access

Of the increase in health funding announced in the government's 2004 budget, $38 million is for highly specialized, province-wide services like cardiovascular surgery, neurosurgery, major organ transplants, renal dialysis and psychogeriatric services. (Government of Alberta, 2004b).

Increased funding likely will not achieve any permanent reduction in waiting times or increased patient access to the system in Alberta. On numerous occasions, provincial governments have provided more money to health care in order to reduce waiting lists, yet the lists continue to grow in Canada: from 9.3 weeks from GP to treatment in 1993 to 17.7 weeks in 2003 (Esmail and Walker, 2003). According to at least one study, conducted by Dr. Martin Zelder, former director of health policy research at The Fraser Institute, additional health spending did not result in reduced waiting times or increased rates of treatment by specialists from 1993 to 1998 (Zelder, 2000c). Another, more recent study based on data from 1993 to 2001, suggests that increased health care spending, unless spent specifically on doctors' services or pharmaceuticals, is in fact correlated with increased waiting times (Esmail, 2003). Estimates are that Canadians were waiting for more than 875,000 elective procedures in 2003 (Esmail and Walker, 2003) and that, in 2001, 1.4 million Canadians experienced difficulty getting specialist services such as diagnostic testing and non-emergency surgery (Statistics Canada, 2002a).

In Alberta in 2003, residents were waiting for 68,082 procedures, which represent about 2.2 percent of the population if one procedure is

7 The estimated impact of the determinants of health on the health status of the population are as follows, based on data from the Canadian Institute for Advanced Research: social and economic environment, 50 percent; health care system, 25 percent; biology and genetic endowment, 15 percent; physical environment, 10 percent (Conference Board of Canada, 2004).

equivalent to one patient waiting, compared to a national average of 2.8 percent. Alberta's waiting times, from GP to treatment, have gone from 10.5 weeks in 1993 to 18.5 weeks in 2003 (Esmail and Walker, 2003). At the same time, the number of adult open heart surgeries performed in Alberta increased from 2,265 in 1999/2000 to 2,445 in 2001/2002; the number of joint replacements went from 4,301 in 1999/2000 to 4,869 in 2001/2002; and the number of MRIs performed as of September 2002 increased 22 percent over the same quarter the year prior (Alberta Health and Wellness, 2002b). As well, the number of people waiting in hospital or urgently in the community for long-term care was 884 on June 30, 2002, up four percent from 847 the year before, despite that there were 6,190 people placed in long-term beds from July 2001 to June 2002, which is six percent higher than the 5,844 people placed in the previous year (Alberta Health and Wellness, 2002b).

Given that Alberta has been successful in increasing its service rates and yet wait lists have continued to grow, it is unclear how more funding is going to solve Alberta's problems. The online wait list registry has been operational since last fall and private facilities have been performing certain procedures for about four years now. Within the boundaries of the Canada Health Act, the province could increase the number of services contracted out to the private sector, which accounted for 0.15 percent of provincial health expenditures in 2002/2003 (Alberta Health and Wellness, 2004h). It could also change the way in which it funds hospitals, which accounted for 38.6 percent of total public health spending in 2003 (Canadian Institute for Health Information, 2003d). Changing just this one component of health policy would mean better value for money, higher quality services for patients, and reduced waiting times.

Hospitals

Hospitals in Alberta receive an annual operational budget from the provincial health plan (a block grant or global budget) to fund the delivery of care.[8] The rationale behind this funding program is that it provides the province with a direct means of controlling hospital expenditures or costs (Leonard *et al*., 2003; Or, 2001).[9] The predictable result of this payment scheme, however, is fewer services and a lower standard of care for patients.

Block grants disconnect the funding from the provision of services to patients. Incentives to provide a higher or superior quality of care to patients are virtually absent, particularly in the current uncompetitive environment. There is also no incentive to function efficiently, especially in the presence of soft budget constraints (Gerdtham *et al*., 1999). On the other hand, administrators have an incentive to discharge patients quickly, avoid admissions of costly patients, and shift patients to other outside institutions as a means of controlling expenditures (Leonard *et al*., 2003).

Reforming this payment scheme to one based on the number and type of procedures actually treated would create powerful incentives to deliver a greater quantity and quality of services

8 Typically, block grant funding schemes separate operations funding and major capital investment funding (Oxley and MacFarlan, 1994).

9 In practice however, hospital budget limits are often "soft" and not strictly enforced. In countries where they have been enforced, such as the UK for example, hard budget constraints have been associated with rigidities in resource allocation, and the rationing of health services through waiting lists and other measures (Koen, 2000).

without leading to dramatic cost increases. This method of funding, best considered a prospective fee-for-service,[10] is most commonly known as the diagnostic related group (DRG) payment system.[11] The idea is fairly simple: the service provider is paid a fee for each individual treated based on the expected costs of treating the diagnosis of the patient at the time of admission. This is distinctly different from a retrospective payment scheme, where all services actually delivered to the patient, regardless of need, cost, or efficacy, are reimbursed by the insurer.

Unlike a block grant, a DRG-based payment creates incentives for hospitals to treat more patients and to provide the types of services that patients desire. If a provider fails to meet patients' expectations under a DRG-payment regime, their departure to another provider immediately results in lower revenues. This competition for patients will result in better care and will not lead to the dramatic cost increases that have been associated with retrospective fee-for-service payments (Weisbrod, 1991). Since fees are based on the average costs of treating a patient's particular illness or condition, and not based on the services actually delivered, hospitals retain the incentive to control costs in order to avoid losses (or maximize surpluses).

Numerous studies on the shift from block funding to output-based payment schemes have found that the reform results in substantial benefits for the patient population. Gerdtham *et al*. (1999) found that Swedish county councils that moved to an output-based reimbursement system following the reforms in 1993 and 1994 became more efficient than those councils that had not reformed—they estimated the potential cost savings to be approximately 13 percent. Håkansson (2000) found that the Stockholm county council experienced an 8 percent increase in inpatient care, a 50 percent increase in day surgeries, and a 15 percent increase in outpatient visits, which all added up to an 11 percent increase in activity overall after the move to DRG payments. Despite the increase in activity, total costs actually fell 1 percent, due both to fewer personnel employed in the hospital sector and a DRG price decrease of 10 percent in January of that year. In general, Swedish counties that moved to prospective payment systems outperformed those counties that did not, both in terms of increased output and productivity (Håkansson, 2000).

These changes in hospital efficiency do not appear to have been accompanied by reductions in the quality of or access to care. Håkansson (2000) finds no evidence that the decreases in length of stay that resulted have had a negative affect on patients (in terms of readmissions to hospital) or that elderly patients have been discriminated against. Svensson and Garelius (1994) find no evidence of providers giving treatment to only the simplest or most profitable cases (cited in Håkansson, 2000). Finally, Charpentier and Samuellson (1999, cited in Håkansson, 2000) note that the greatest downside to the purchaser-provider split and the financing reform accomplished in Stockholm County was an inability to handle the new developments at the central management level.

10 A *prospective* fee-for-service payment scheme funds patient care based on the disposition of the patient at the time of admission for care—dash specific fees or rates are associated with specific illnesses or conditions. For more discussion on the differences between *retrospective* and *prospective* output-based payment schemes, see Weisbrod (1991).

11 DRG payment schemes are the most widely used form of prospective reimbursement schemes, where payments are based on the costs of treating specific disease categories.

In Italy, Aparo *et al.* (1999) found that the move to DRG-based inpatient care financing resulted in a 32 percent reduction in the cost per discharge, a 58 percent reduction in the average length of stay, and a 62 percent increase in the intensity of care (inputs per day) between 1994 and 1998. In total, the Italian health care system was able to care for twice as many patients in 1998 as in 1994 (despite going from 5.6 inpatient acute care beds per 1,000 population to 5.0), and that hospitals did not resort to admitting less ill patients to increase revenues (Aparo *et al.*, 1999; OECD, 2003).

Similarly, Clemmesen and Hansen (2003, cited in Siciliani and Hurst, 2003) found that the move to partial DRG-based financing in Denmark also led to increases in productivity. Their study, following 18 common surgical procedures after the health reform in 2000, found that hospital activity increased by 13 percent in the year immediately following implementation. Equally important, average waiting times fell 17 percent, from 26 weeks to 21.5 weeks (Clemmesen and Hansen, 2003, cited in Siciliani and Hurst, 2003; Kirby, 2002). This mirrors work done by the OECD which found, in a review of 20 OECD countries, that waiting lists are less likely to be seen as a problem in the presence of activity-based financing for hospitals (Siciliani and Hurst, 2003).

Prospective fee-for-service funding systems have also been successful outside of Europe. In Australia, the first two states to undergo hospital finance reform enjoyed increases in the quantity of services while also enjoying decreases in the size of hospital budgets (Hilless and Healy, 2001). The state of Victoria in particular, now known as the most efficient producer of case-mix adjusted public hospital services in the country, experienced a 25 percent reduction in costs per patient treated between 1991-92 (the last year before reform) and 1996-97 (Steering Committee for the Review of Commonwealth/State Service Provision, 1998; Duckett, 2000).

A slightly different type of review on the efficiency improvements that can result from the implementation of a superior remuneration scheme focuses on the differences between two countries: Austria and Canada. Leonard *et al.* (2003), comparing six major clinical categories of inpatients in both countries, found that patient stays were actually longer under case-mix based remuneration in Austria than they were in block-funded Canadian hospitals. These findings suggest that an appropriately designed DRG-based payment system and appropriate direction from policy makers can produce longer lengths of stay than a globally-budgeted hospital system, despite the fact that both funding policies create an incentive to shorten stays.

DRG-based payment schemes also facilitate the introduction of competition into the hospital sector. Because the cost of performing procedures is clearly identified—government purchasers know exactly what they are purchasing and for how much—contracting for surgical or hospital care, or even deregulating the hospital sector and allowing freedom of choice for patients, is more easily accomplished. Sweden's Stockholm county has taken this one step further and partly bases the value of DRG reimbursements for all providers on the most efficient provider's cost structure (Lofgren, 2002).[12]

Primary care reform

Also announced in the Alberta government's 2004 budget—and related to the way in which health care providers are paid—is an increase of $45 million to support health reform to meet Al-

12 St. Goran's hospital, a private for-profit service provider, is historically the most efficient hospital in the county (Lofgren, 2002).

bertans' needs in more collaborative and innovative ways, including building Alberta's primary health care capacity, expanding the province's public education campaign, and providing alternative funding for academic medicine. As well, there is an increase of $67 million to be spent on Alberta's tri-lateral agreement among government, physicians, and health regions to cover fee increases and implement local primary care (Government of Alberta, 2004b).

With the changes in primary care, the province is hoping that the "programs will improve access to care and increase public satisfaction and trust in receiving primary health care services from a range of health care providers" (Government of Alberta, 2003f). It believes that the formation of primary care teams will result in not only improved patient care, but a more supportive environment that will be appealing to many providers. In these teams, family doctors will be remunerated on a contract or salary basis rather than fee-for-service. The government's hope, no doubt, is that changing the method of remuneration—both in primary care and for academic physicians—will result in doctors and other health providers spending more time with their patients or research, and will enable resources to be used more efficiently and funding to be more predictable, since doctors will be paid a set amount rather than for every service they render to each patient. However, while there is evidence that changing the method by which doctors are paid will not result in them underproviding services (for example, see Shortt, 2001), there is compelling evidence from around the world that replacing fee-for-service with salary or capitation (a form of salary based on the physician's patient load) reduces the services providers offer—all services, not just "unnecessary" care or services (Ferguson, 2001). Salary payment schemes also remove the incentive to produce beyond a minimal standard, both quantitatively and qualitatively, when compared to output-based remuneration (Feldman *et al*., 1981). Finally, according to a recent OECD study, countries that employ fee-for-service remuneration are less likely to experience problematic waiting times (Siciliani and Hurst, 2003), a finding that is broadly consistent with the existing literature on the superiority of fee-for-service remuneration.

Further evidence on the benefits of fee-for-service remuneration policies can be found in a number of peer-reviewed studies. Hickson, Altemeier, and Perrin (1997), in a study comparing paediatric clinics, found that fee-for-service physicians scheduled more visits, provided better continuity of care, and were responsible for fewer visits to the emergency room than their salaried counterparts. Wilson and Longmire (1978) found, in a comparison of six hospitals, that surgeons in the two fee-for-service hospitals performed almost 50 percent more procedures in one month than did the surgeons in the two salaried hospitals. Ransom *et al*. (1996), comparing the number of services performed in a single gynaecology clinic under varying payment schemes, found that the number of procedures performed fell 15 percent when physicians moved from a fee-for-service scheme to a salaried scheme. The authors also noted that the number of elective procedures was most affected by the change in remuneration. Finally, Gosden *et al*. (2001), in a review of the literature, suggested that the quantity of primary care services provided by physicians was higher under a fee-for-service regime than under a capitation payment regime.

In the end, salary or capitation could end up making the health system more costly:

> American evidence suggests that physicians working under comparable systems provide about 25 percent fewer office visits than do fee-for-service physicians. The

> one Canadian study, which contains the Canadian data necessary to study the question, finds that physicians working under fee-for-service provide six more patient contact hours per week than do doctors working under other remuneration systems. On the American figures, introducing capitation would require a 30 percent increase in physician stock simply to maintain current patient access, with each of those additional physicians earning roughly what the average GP does now. That translates into a significant increase in the costs of health care, just to maintain present access. (Ferguson, 2001)

There must be room in any payment mechanism to reward, with bonuses or other measures, high-quality performance. Mixed payment systems—combining capitation and fee-for-service, for example—can reduce some of the potential difficulties that arise under a single payment system. The capitation element can moderate the tendency towards excessive treatments that can occur under pure fee-for-service approaches, and the fee-for-service element can moderate the potential for family doctors paid by capitation to register too many patients and underserve them (Oxley and MacFarlan, 1994).

In the hospital setting, the choice of physician compensation by the hospital depends on several factors: risk, costs of supervision, the nature of the output, and the price of medical care. If there is generous insurance coverage of hospital services and limited reimbursement of physician services, then a hospital will have more salaried physicians; if the conditions are such that a hospital wishes to provide more patient services, then they will rely more heavily on incentive compensation for staff physicians (Feldman *et al*., 1981).

Ultimately, the best remuneration systems are those that are output based. Salaried physicians, unless well supervised, will tend towards less output because their pay is not dependent on the quality or quantity of services provided. Fee-for-service payment schemes, or some mixed payment scheme that has an output-based component in areas where strict fee-for-service would not provide adequate income for physicians, are clearly the superior choice for remuneration in terms of the quantity, and possibly the quality, of care provided. Moving from a fee-for-service payment scheme to a strict salary scheme would only serve to reduce the cost-effectiveness of the health care system in Alberta—costs would either rise to maintain services, or service provision would fall to maintain cost. Neither would be acceptable in a province that already operates an incredibly expensive health care system relative to other OECD countries, with long waiting times in some areas relative to the rest of Canada.

In relation to costs, another aspect of Alberta's health care reform is to increase the participation of other health care providers, such as nurses, in the care of patients. It recently increased the scope of practice of nurse practitioners. Such an approach is often considered to be a less expensive method of care provision because of the lower costs of training such practitioners. However, as Prof. Brian Ferguson points out, the cost of educating a provider is not the primary determinant of how much they get paid:

> The ultimate determinant of how much a provider earns is the value of the services they provide. If NP [nurse practitioner] services are equivalent to MD services, the price NPs get paid for each service will rise to equal that of an MD providing the same service. This is what has happened in the US, to the point where many proponents of NPs acknowledge that they have lost their cost advantage over MDs. According to one salary survey, turned up by an internet search, the average American NP

> salary is about $60,000 US, which translates into about $90,000 Canadian. That's less than an MD earns, but it's not cheap, and unless Canadian salaries are in the same general range, a lot of the NPs we train here will head straight for the American market…. If those NP services are in fact of comparable quality to MD services, NPs have every right to expect to be paid as much, on a per service basis, as an MD would be paid for providing them. If that isn't the case at first, one good pay equity lawsuit will make it so. (Ferguson, 2001)

It is basic misunderstandings such as these—that paying physicians differently or that by hiring other practitioners to replace physicians will necessarily save the health system money—that shed light on the problem with a government-controlled health care system. The difficulties of micro-managing the elements of such a complex organism are myriad.

The encouraging aspect of Alberta's approach to primary care is that there is some competition built into the process. Last year, a total of 44 proposals were submitted from regional health authorities, health professional associations, educational institutions, physicians, and non-profit organizations. Ten projects were awarded to multidisciplinary teams, ranging from initiatives dealing with chronic disease management to improving the primary care available in certain regions to enhancing child and youth health outcomes to treating mental illness (Alberta Health and Wellness, 2003d). Whatever the method of remunerating the providers within these groups, it should include a connection to the results achieved by their organization. If they are unable to meet their contractual obligations, then the group must determine some other way of making ends meet and be allowed to "go out of business" if they fail to do so, or at least not have their funding renewed.

This may be too much to ask in the current labour environment in Alberta, where primary health care reform projects such as the 10 mentioned above, are seen by some as "the next step in the privatization of public medicare" (United Nurses of Alberta, 2003f). Prior to the agreement that was reached between doctors, the ministry, and health regions, the United Nurses of Alberta commented on the secrecy of the negotiations taking place and, while it admitted that "no details have come out yet," the group claimed the agreement would be "a plan to sell off primary care to physician-owned corporations. Doctor corporations will sign business contracts with health regions to provide public health services, everything from immunization to 24-hour clinics. The doctors' corporation will hire the registered nurses and other health providers they need and then bill the region for the services they provide. The plan would look suspiciously like the American for-profit health management organizations, HMOs" (United Nurses of Alberta, 2003f).

This fear now seems groundless, given the nature of the projects that the Alberta government has funded to date. As well, the comparison of a primary care team with an HMO is not appropriate in this case. A primary care team is really no different from a typical, privately-owned physician's office, except that it has a larger scope of practice, and includes other health care practitioners in the provision of care. An HMO is something quite different, though it would be similar to a physician group practice being remunerated under a capitation scheme in which the group had to pay for *all* the health services provided to patients. In an HMO setting, patients enroll with an organization and pay monthly fees, as well as co-payments for each office visit and prescription; patients are restricted to practitioners who have signed on with their HMO. This is not the situation in Alberta, where patients are free to choose their care providers, and still receive

"free" care at the point of service for publicly insured services.

Continuing, long-term, and home care

Continuing, long-term, and home care are other areas that have proven controversial because of the role played by the private sector in them. Albertans are expected to contribute to the costs of these services, the demand for which has been increasing as Alberta's population grows and ages.

For their part, the regional health authorities have submitted to the ministry 10-year plans for continuing and long-term care. For its part, the ministry has developed a forecasting model to help determine future demand for long-term care, supportive living, and home care, and developed strategies to expand supportive living options. It has released the *Healthy Aging and Seniors Wellness Strategic Framework, 2002-2012*, which identifies provincial priorities and provides a planning tool for regional health authorities and community organizations (Alberta Health and Wellness, 2003b).

The number of persons waiting for long-term care placements in 2002/2003 was generally similar to levels reported for 2001/2002 (Alberta Health and Wellness, 2003b). In 2003, there were 340 people waiting in an acute care facility and 457 waiting urgently in the community for placement in long-term care (Alberta Health and Wellness, 2004c). While the regional health authorities track the number of people waiting for a place in traditional long-term care beds, there is no consistent collection across the province on waiting lists for home care or supportive living services (Alberta Health and Wellness, 2002b). The health authorities do, however, monitor spending on home and community-based care, the numbers of home care clients, service hours provided, etc.

In 2001/2002, the ministry of health finalized partnerships with private and voluntary sector organizations to develop new long-term care facilities: four projects were completed and 361 new beds were opened, with capital funding approved to develop more than 2,700 new long-term care beds over the next two or three years (Alberta Health and Wellness, 2002b).

In 2003, the government increased the accommodation rates in long-term facilities by 40 to 48 percent, depending on the type of accommodation, "to improve the quality of resident care" and bring the fees "closer to the true cost of room and board," while at the same time expanding its financial assistance programs to minimize the impact of the price increase on low-income long-term care residents (Government of Alberta, 2003e). The 2004 provincial budget allocated $11 million to fund expected increases in the number of eligible seniors under the Alberta Seniors Benefit and the full-year cost of assistance with the August 2003 increase in long-term care accommodation rates (Government of Alberta, 2004b).

There were critics of the size of the increase in accommodation fees. One labelled the move "a public bailout of for-profit care providers" and warned that the line blurs between what is considered a health service, and therefore covered by government, and what is deemed room and board, and therefore is covered by individuals. This lack of clarity, not only in Alberta but in other provinces, is an example of interprovincial cooperation in the "way health ministries have been coordinating how to best beat up on old cripples," according to Wendy Armstrong, author of a report on elder care prepared for the Consumers' Association of Canada (United Nurses Association of Alberta, 2003g).

While critics' concerns may be well placed regarding the size of the increase in fees at one time, the government notes that, except for an increase of up to $4/day in January 2002, the rates had not changed since 1994. If this is the case, the fee increase cannot be considered a public bailout of the private sector, since total health expenditures in Alberta (using current dollars) have been increasing at a faster rate, with the exception of 1993 to 1996, when health spending decreased in the province (Canadian Institute for Health Information, 2003d). Just looking at the last four years, the annual percent change in total health expenditures in Alberta was 9.3 percent in 2000 and 13.5 percent in 2001, with a 9.9 percent increase forecasted for 2002 and a 6.9 percent increase for 2003 (Canadian Institute for Health Information, 2003d). Long-term care facilities cannot be expected to protect residents completely from such increases in costs and still remain solvent.

As for the lack of clarity in what long-term care services are provided by the public sector and which are not, this is a problem not unique to long-term care, and perhaps the list of what the public sector covers could be clearer. However, governments cannot afford to provide patients with *everything* they want and funding priorities must be set. As discussed above, Alberta has recently decided to maintain the list of currently funded services and review new health services based on guidelines proposed by the Expert Advisory Panel to Review Publicly Funded Health Services (2003). This process should be transparent—at the least, the information and criteria on which the priority-setting decisions are based should be made publicly available. Once the funding decisions have been made—which procedures to cover or which practice guidelines to implement—individuals (patients, providers, and those directly affected by the policy/choices) should have the right to challenge the decisions.

Private surgical facilities

In September 2000, amid much opposition, the Alberta government passed the Health Care Protection Act (Bill 11). The act prohibits private hospitals; limits the operation of private, non-hospital surgical facilities to those approved by the minister of health; prohibits the charging or paying of a fee to jump the queue for faster access to service; prohibits non-hospital surgical facilities from charging facility fees to patients; prohibits charges for enhanced medical goods and services above the actual cost to provide them; and requires that no fees be charged for enhanced goods or services unless the nature and cost of these goods and services is explained fully to patients. The regulations govern facilities through which the regional health authorities provide Albertans with insured services outside of hospitals, such as cataract and oral surgery. Facilities are allowed to provide insured surgeries only when they have a contract with a health authority and RHAs will only be allowed to enter such contracts when they show it will benefit the public system through maintained or improved access, reduced waiting lists, or reduced costs. The act includes reporting requirements related to the services provided under approved contracts.

According to Alberta Health and Wellness (2004h), the total cost of contracts with surgical facilities under the Health Care Protection Act was $10.2 million in 2002/2003, while total provincial expenditures that year was $6.9 billion. Therefore, contracts with surgical facilities account for approximately 0.15 percent of provincial health spending. To date, the minister of health has approved 35 contracts. Of the nine regions, only the Calgary Health Region, the Capital Health Authority, and the Headwaters Health Authority have contracts with private surgical facilities, for the following *insured ("medically necessary") day surgery* services: ear, nose, and throat; ophthal-

mology; oral surgery; pregnancy termination; dermatology; and plastic surgery.

A criterion for the approval of a contract with a private facility is that it must comply with the Canada Health Act. As well, health authorities must show the minister that no conflict of interest exists in the contracting process, that patient safety is assured, and that there are demonstrable public benefits. Increased access to services seems to be the most prevalent benefit cited in contract proposals, while some explain that the contract increases patient choice or allows public facilities to be used more effectively for more complex procedures (Mar, 2000). In some cases, cost savings have also been reported (Government of Alberta, 2002a).

The passing of Bill 11 was controversial. A previous version of the bill—the Health Statutes Amendment Act (Bill 37)—was shelved in 1998 due to massive opposition from labour unions, seniors' groups, other health care groups, and academics, who believe that the private sector should play no greater role in health care (Cairney, 1998; James, 1999). The same groups vocally opposed the Health Care Protection Act. A *Globe and Mail* poll in 2000 suggested that only 39 percent of Albertans supported the legislation (Shortt, 2001). An Angus Reid poll that same year showed that a slight majority of Albertans (52 percent) opposed the bill, but that opposition to it was declining (Virani, Kanji, and Cooper, 2000). Other opinion polls showed varying results.

Critics claimed that the act would "open the doors to private hospitals and two-tier medicine" and "open the door to competition from the US" (Kermode-Scott, 2001). Supporters, such as the Alberta Chambers of Commerce (2000), pointed out that many of Canada's health services were already being delivered through private providers, from walk-in clinics, labs, and diagnostic facilities of individual doctors, nurses, chiropractors, physical therapists, and others: Bill 11 would allow for increased access to services, innovation, and cost competitiveness.

While the controversy has not abated entirely, it has become less vehement, although it briefly intensified when, in 2002, the Health Resource Centre (HRC), a 37-bed private surgical facility in Calgary, was approved by the ministry of health to provide five procedures requiring *overnight* stays. The approved services are primary total hip arthroplasty; uncomplicated, primary total knee arthroplasty; uncomplicated, primary total shoulder arthroplasty; uncomplicated, lumbar posterior spinal fusion not exceeding two disc-space levels; and lumbar spinal laminectomy, not exceeding two disc-space levels (Alberta Health and Wellness, 2004h). The HRC is permitted to perform up to 441 procedures annually until January 2005 for patients who are *not insured* under the Canada Health Act, such as Workers' Compensation Board (WCB) clients, the military and RCMP, and residents of other countries (Government of Alberta, 2002c).

In announcing the approval of the HRC for the overnight procedures, the Alberta government assured Albertans that "no Alberta government health dollars will be spent on the facility, or towards the fees of the physicians employed there" (Government of Alberta, 2002c). Other "assurances" provided by the government (2002c) were that:

- HRC is accredited for medical safety by the College of Physicians and Surgeons of Alberta.
- No Canadian resident will be able to pay directly for, or use private insurance to pay for, procedures at HRC.

- HRC must provide detailed monthly and annual reports to the health minister outlining the number of procedures performed, patients' residence, and source of payment.
- HRC must report all critical incidents, adverse outcomes, and significant mishaps to the minister within 24 hours of occurrence.
- Physicians at the facility must comply with the Medical Professions Act and by-laws related to conflict of interest and ethical issues.

In approving the HRC for the five orthopaedic procedures, the minister listed four public benefits of the decision, two of which most people would agree are benefits: increased operating room space and recovery time in hospitals, and faster turnaround time between specialist consultation and surgery, helping put injured workers back on the job more quickly. The other two public benefits are more controversial. According to the minister, the other advantages of the HRC proposal are the fact that no government money is directed to the centre, and that no Canadian resident is allowed to pay directly or use private insurance to pay for services at the facility. The minister also notes that doctors who work at the HRC must do so in addition to their work in the public sector—the "HRC will neither employ nor consider referrals from doctors who have opted out of the Alberta Health Care Insurance Plan" (Mar, 2002). There are no such restrictions on nursing or other staff.

In the four years since the Health Care Protection Act was passed, only a very minimal amount of the annual health care budget has ever been spent on services contracted to private facilities. Opponents of an increased role for the private sector in health care, such as Friends of Medicare, believe that not much has changed since Bill 11 because the health authorities know they don't have the support of most Albertans to contract out services, and Premier Klein has conceded that Albertans haven't embraced his reforms, although he's determined to change that (Henton, 2004b).

A recent announcement by the Assembly of First Nations (AFN) in Alberta may force the issue of privatization further. Jason Goodstriker, regional chief for Alberta with the AFN, said various bands in the province are considering proposals for private health facilities, including one for a private hospital near the Calgary airport (Humphreys, 2004b). While the Health Care Protection Act prohibits private hospitals and there are federal and provincial stipulations against charging fees for medical services, it is thought that they would be unenforceable on reserves. A similar situation has arisen in Saskatchewan, where the Muskeg Lake Cree Nation plans to build a for-profit diagnostic imaging clinic on land it owns in urban Saskatoon (Humphreys, 2004a).

Drug costs

Private financing of pharmaceuticals is more accepted in Canada—it has always dominated, although there has been a gradual trend toward greater public funding over the past 25 years (Conference Board of Canada, 2004). In 2002/2003, Alberta spent more than $413 million on Alberta Blue Cross benefits, up 13.6 percent from $364 million the year before—with drugs accounting for 95 percent of these expenditures. Also that year, 177 new drug products were added to the Alberta Health and Wellness Drug Benefit List, following review by the Expert Committee on Drug Evaluation and Therapeutics, bringing the total number of drugs on the list to more than 3,600 (Alberta Health and Wellness, 2003b). In 2003, drugs accounted for 7.1 percent of total public health spending and 31.0 percent of total private health spending (see table 3.5 for dollar figures).

In the government's 2004 budget, an increase of $76 million was allotted, mainly for volume and cost increases of drug benefits to seniors (Government of Alberta, 2004b). And drugs will continue to absorb a greater proportion of health spending—in Canada, the rate of increase in drug spending has consistently outpaced the overall rate of increase in health care spending since 1984 (Conference Board of Canada, 2004). This is not necessarily a problem *per se*, because pharmaceuticals have brought an enormous increase in the capability to fight and control disease. In many cases, they have replaced much more expensive interventions. For example, 40 years ago, one of the most common procedures performed in Canadian hospitals was a vagotomy and pyloroplasty, an intra-abdominal surgical procedure designed to relieve the symptoms of peptic ulcer disease, but as a result of a number of drugs that have come on the market, this procedure is seldom performed today, and the consequence is a substantial reduction in costs combined with considerable reduction in patient suffering and disability (McArthur, Ramsay, and Walker, 1996). There are many examples of how new drugs have reduced costs, but these are often overlooked when the sole focus is on the cost of the drugs.

Nonetheless, to try and contain the growth in pharmaceutical spending, Alberta uses the results of national drug evaluations to expedite the review of generic drugs, and the province will cooperate in national efforts to set uniform best practices for prescription drugs. As well, the regional health authorities and Alberta Cancer Board buy drugs in bulk to reduce costs (Alberta Health and Wellness, 2004a). Other measures traditionally used to combat the effect of drug costs on public (and private insurer) expenditure are cost-sharing mechanisms, such as co-payments, limiting the scope of coverage, the use of generics over brand names and education initiatives, all of which are being used in Alberta.

In its 2004-2007 business plan, Alberta Health and Wellness refers to pharmaceuticals only briefly, stating that "protect[ing] Albertans from catastrophic drug costs" is one of its strategies to improve access to health services. Given the competing demands for health care funding, this seems to be a sound plan.

Leading the health system

The ministry's third core business focuses on the system's sustainability and organizational excellence within the ministry itself. For the latter goal, the performance measures include not only the level of satisfaction Albertans have with how their inquiries are handled by Alberta Health and Wellness, but the satisfaction of other ministries with the department. For the former goal—that of sustainability—the ministry has laid out three main strategies that focus on managing the system, the health workforce, and technology.

System management

In addition to vague plans, such as "to provide leadership in federal-provincial relations to maintain Alberta's ability to meet local health needs" and "collaborate with health authorities and other partners on integrated policy and planning initiatives" (Alberta Health and Wellness, 2004c), Alberta Health and Wellness is in the process of implementing multi-year performance agreements with the health authorities.

The *Mazankowski Report* noted that, as of December 2001, the regional health authorities (which were created in 1995) were providing "better integration of the full range of health services, from hospital care to home care, long-term care, and promotion and prevention activities, and an ability to shift resources to priority areas. But the system is not without its challenges" (Premier's Advisory Council on Health, 2001).

Some of these challenges were that the majority of funding for the regional health authorities (RHAs) comes from the province, and regional health boards spend a lot of time lobbying the provincial government for increased funding; that physicians (the tests they order, surgeries they do, and the treatments or medications they prescribe) affect RHA budgets but they have no control over these costs; there are a variety of political influences involved in decisions made by RHAs; RHAs are often caught between government and health providers, with little ability to respond to providers' concerns; and that managers in the health system spend too much time dealing with crises and have little time to plan ahead, explore innovative approaches, or assess whether certain programs are working or not. The *Mazankowski Report* also mentioned that Alberta's auditor general had raised concerns about accountability, governance, and management in regional health authorities and pointed to weaknesses in business planning and budgeting and gaps in performance reporting.

For fiscal year 2002/2003, the health authorities in aggregate reported a $72 million operating deficit, after a prior year deficit of $21 million. Since March 31, 2003, the regions have been restructured into nine from 17, but this is unlikely to translate into more effective and efficient administration and delivery of health services because, while the health authorities have a significant role in planning and providing for their regions' health needs, they are still, ultimately, basically advisory bodies to the minister of health.

The same problem exists with the introduction of multi-year performance agreements. While these agreements should resolve some issues, such as planning ahead, assessing whether programs are working and any budgeting and performance reporting weaknesses—some of which already have improved since 2001—they will not change the fact that most of the health regions' funding still comes from the provincial health ministry. Contributions from Alberta Health and Wellness provide 85 percent of total health authority revenue (Alberta Health and Wellness, 2003b). As well, physicians remain under the purview of the health ministry, although the regions have been involved in the negotiation of Canada's "first ever eight-year, tri-lateral agreement with physicians" (Government of Alberta, 2004a). And, even though the regions are able to contract out surgical services to private providers, for example, the ultimate authority for those decisions lies with the minister of health.

Despite all of Alberta's health reforms, the system still operates as a monopoly, and all of the observations made by the *Mazankowski Report* are still relevant. With varying degrees of input from others in the health system, the health ministry decides which services are "medically necessary" and, therefore, which services the government will insure. The ministry pays for all the insured services provided and forbids, by law, the availability of private insurance for these services. It outlaws people from obtaining insured services outside the public system, except where there are contracts with the public system. It directly or indirectly administers and governs care. And it defines, collects, and reviews information on its own performance (Premier's Advisory Council on Health, 2001):

> In almost every other public and private area, monopolies are simply not accepted. With banks and other financial institutions, retail stores, bookstores, dentists, optometrists, or chiropractors, Canadians and Albertans understand and support competition, and we're reluctant to accept a situation where we have only one choice. In education, people have choices about what college, university, or technical institute they attend.

> Parents can choose which school they want their children to attend—public or private, bilingual, immersion, or straight English, and a whole range of specialized programs are available. Schools and post-secondary institutions compete for students, introduce new programs to attract more students, and publish their results. The education system has developed into a customer/student-oriented system.
>
> In the public health system, none of this happens. We can choose our own family physician, but frequently, that's where the choices end. We go to specialists referred by our family physicians, get tests suggested by a physician, go to physiotherapy if it's prescribed, take the medications our doctor prescribes, go to the hospital we're directed to, and wait in line if the services we need are not immediately available (Premier's Advisory Council on Health, 2001).

In addition to the general problems associated with monopolies, such as higher prices, slower adoption of technology, and poorer customer service, the impact of having only one employer in the health care sector—the government—makes labour issues more difficult to resolve without service disruption and to the satisfaction of workers.

Health workforce

In Canada, physician societies negotiate with the government for the overall amount to be allocated to physician services and, hence, to physicians' incomes. Nurses' unions, hospital employees unions, and other health providers whose services are covered by the province's insurance plan all negotiate with the government for their wages. While there are hospital administrators and other bureaucrats in the Canadian system, it is the government who ultimately pays health care workers.

What this means in practice is that, if the medical society or union doesn't like the wages or fees offered by their employer and labour negotiations deteriorate, they threaten job action in the form of work slowdowns or stoppages. These actions can effectively close down most of a province's health care system. There are no alternative providers of care to whom patients can turn, so treatments are delayed and patients suffer. These costs are almost impossible to quantify, but they exist and are a consequence of the Canada Health Act's public administration principle coupled with provincial legislation prohibiting private financing of publicly insured services.

The minimization of these costs is one of the reasons behind Alberta's recent passing of Bill 27, which introduces major changes to the Labour Relations Code. Under Bill 27, the Labour Relations (Regional Health Authorities Restructuring) Amendment Act, unions and employers will negotiate under four functional bargaining units: nursing; auxiliary nursing; paramedical, professional, and technical services; and general support services. All health care workers in similar jobs in the same health region will negotiate as a unit, so each of the nine health regions will negotiate with only four bargaining units, reducing the total number of collective agreements to 36 from more than 400 (Government of Alberta, 2003c).

Since strikes or lockouts threaten patient access and compromise patient safety, regional health employees in any capacity provide essential services. Bill 27 establishes a common process—compulsory arbitration—to resolve labour disputes, bringing the 10 percent of health care employees (mostly those who provide community, mental health, and home care) who could legally

strike in line with the 90 percent who cannot (Government of Alberta, 2003c).

Among other amendments is the removal of nurse practitioners from collective bargaining. They will take on new duties in the health care system to improve patient access to medical care. They will no longer be covered by the code and will have to negotiate their own contracts for more flexible working hours and conditions (Government of Alberta, 2003c).

In response to the passing of Bill 27, the Alberta Union of Provincial Employees brought a complaint to the International Labour Organization (ILO), which is sponsored by the United Nations. The ILO said the bill violates the UN convention on freedom of association by unfairly removing the right of nurse practitioners to form unions and that the right to strike should only be removed in cases where the "life, personal safety, or health of the whole or part of the population" would be endangered. The ILO felt that the government did not consult adequately with its employees before enacting the legislation (Canadian Press, 2004).

Other unions also tried to challenge the legislation in the courts. However, in January of this year, Queen's Bench Justice Jack Watson dismissed the charges that Alberta's Labour Relations Board was biased or swayed by the government and the health regions when they consulted the board in drawing up the legislation (Canadian Press, 2004; United Nurses of Alberta, 2004c).

While the government reached contract agreements with the Health Sciences Association of Alberta (through arbitration after almost two years without a contract) in February 2004 and with the Alberta Medical Association in December 2003 (after more than a year of negotiations), the health regions are still attempting to reach an agreement with the province's nurses, who have been negotiating for a new contract since January 2003 (United Nurses of Alberta, 2004c; Alberta Medical Association, 2003; United Nurses of Alberta, 2003d). Some of the issues involved are the regions' desire to move nurses to different units or elsewhere within a health region, assign permanent evening and night shifts, abolish the number of days of rest for part-time nurses, dismiss the idea of minimum staffing and nurse-to-patient ratios, and change shift premiums, overtime, and holiday pay (United Nurses of Alberta, 2003b).

In Alberta, there are concerns about attracting and keeping an adequate supply of doctors, nurses, technicians, pharmacists, and a whole range of health providers. Previous decisions by the government to reduce enrolments in medical faculties and nursing programs are having a serious impact on the near-term shortage of doctors and nurses, and in certain parts of the province, health authorities have serious difficulties attracting and keeping physicians and hiring nurses (Premier's Advisory Council on Health, 2001).

Chan (2002) calculates that, after accounting for the increased demands of an aging population and the entry of more female physicians (who work fewer hours than their male counterparts) into the workforce, the "real" physician-population ratio in Canada declined by 5.1 percent between 1993 and 2000; the "real" physician-population ratio was the same in 2000 as it was in 1987. Much of the decline in physician supply is the result of a sharp drop in Canadian postgraduates entering practice from 1994 to 2000, according to Chan. The main reasons for this decline include longer training requirements, such as the elimination of the rotating internship that had allowed physicians to enter practice as a general practitioner after just one year of postgraduate training, and the decision by some provinces to

increase the ratio of specialist-to-family-medicine residency positions (Chan, 2002). Other factors directly contributing to lower physician supply in Canada include the reduction in medical school enrolment from the graduating class of 1997 onwards, the downsizing of medical school enrolment in the 1980s, restrictions on international medical graduates that were implemented in the mid-1990s, and retirement incentives, such as buyout packages or attempts at mandatory retirement (Chan, 2002). In addition to the elimination of the rotating internship, Chan (2002) points to the decline in opportunities for physicians to return to postgraduate training, and general economic and social policies that may have indirectly encouraged physicians to leave Canada or retire early, such as expenditure control policies in the mid-1990s, limits on the right of new physicians to migrate to other provinces, financial penalties for new physicians wanting to practice in "over serviced" areas, and changes to the hospital sector (closures, mergers).

Estimates are that Alberta may need an additional 1,329 physicians by 2004/2005 (Alberta Medical Association, 2000). Regional health authorities estimated a shortage of about 1,950 nurses in 2001/2002 (Premier's Advisory Council on Health, 2001). In response, the number of medical residency seats funded in Alberta has increased by 15 percent in the past four years and there was a 71 percent increase in first-year registered nursing training spaces from 1997/1998 to 2001/2002 (Alberta Health and Wellness, 2004h).

Various health authorities are involved in programs and initiatives to attract and retain more health providers. With an alternative payment scheme, the Calgary Health Region, with $4.5 million in funding from the ministry, was able to recruit 17 paediatric specialists (Government of Alberta, 2003b). One pilot project between eight provinces, including Alberta, and the federal government—the two-year Provincial Nominee Program—has made it possible for Alberta's health regions to retain 150 foreign-trained health professionals, mainly physicians and nurses, but also a number of occupational therapists and other health providers (Government of Alberta, 2003g). And actions in Alberta to increase salaries and establish other incentives are attracting some physicians and nurses from other provinces (Premier's Advisory Council on Health, 2001).

Health providers have indicated that they feel unappreciated and that there is little understanding of their expectations and views by those in charge of health regions. Many nurses complain about the lack of full time jobs and the requirement to work overtime. At the same time, contract settlements also have an impact on how much nurses are paid for full time versus casual employment—many can earn as much or more on a casual basis (Premier's Advisory Council on Health, 2001).

Most regional health authorities recognize the problems in their workforce and are taking steps to address them. Examples include providing avenues for doctors, nurses, and other providers to be more actively involved in decision-making processes, expanding continuing education, and increasing the number of permanent positions for nurses (Premier's Advisory Council on Health, 2001). As well, the government is trying, with the Work Safe Alberta initiative, to reduce workplace injury rates by 40 percent by the end of 2004, and claims that it has already achieved 10,000 fewer injuries and saved $140 million in medical and compensation costs over the past year (Government of Alberta, 2004b).

While many of the professional organizations talk positively about the need to work together, in reality, they seem unwilling to give up parts of their "scope of practice" unless there is some cor-

responding compensation. In other cases, union contracts require the use of particular health providers even though others could probably do the work and at less cost (Premier's Advisory Council on Health, 2001).

In other instances, legislation is a barrier. The provincial government has taken steps to review legislation for health professionals and examine their various scopes of practice. It has increased the scope of practice for nurse practitioners and, with the Health Professions Act, scopes of practice are no longer exclusive to one profession, although, to date, only nine of 28 professions have regulations under the force of the act (Alberta Health and Wellness, 2004a).

Information technology

In 2002/2003, the ministry developed a funding model for health system information management and information technology requirements, to set ministry-wide priorities and co-ordinate initiatives. It submitted a funding proposal to Health Infoway Inc. as part of the Western Health Information Collaborative, including $19 million for the Pharmaceutical Information Network (PIN) and $6 million for further development requirements. Through Alberta Wellnet, it also developed standing offer contracts for regional health authorities that were purchasing services or equipment to improve their information technology (Alberta Health and Wellness, 2003b). The ministry will have nearly $67 million in 2004-2005 for capital investment, largely for information technology systems such as the Electronic Health Records and the PIN (Government of Alberta, 2004b).

While a shift to computerization and data integration is vital for the better management of the health system and for health care providers to make more effective decisions about the care they provide (eg., decisions about drug prescriptions), the data collected should also be made available—as much as possible given privacy considerations—to the general public. Among the changes provided by the 2003 Health Professions Amendment Act, Bill 52, were amendments that gave authority to the regulatory colleges to collect and share information on individual health providers (Government of Alberta, 2003d). This information sharing should not be limited to health professionals, their colleges, and the government.

Conclusion

Total health authority long-term debt at March 31, 2003, was $28 million, up from $13 million at March 31, 2002 (Alberta Health and Wellness, 2003b). The Calgary Health Region's outlook for 2003/2004 is that its projections of funding increases are insufficient to cover increases in health inflation, operating costs for recently implemented health service initiatives, and new projects planned for the next year (rising personnel, technology, and medication costs); it is in discussions with the government about alternative future funding sources (Calgary Health Region, 2003). The other main health authority in the province, the Capital Health Authority, notes similar cost pressures: labour contracts, staff shortages, population growth, and new technology (Capital Health Authority, 2002). All of these concerns are not new—they existed before the government's *Alberta: Health First* plan, and prior to the *Mazankowski Report*.

Despite the government's implementation of widespread and extensive reforms, the sustainability of Alberta's health system is still in question. This is why the premier and the health minister are talking about "radical changes" and why they are beginning to openly discuss the possibility that the private sector may be able to ease some of the cost pressures on the public system.

This idea, too, is not new. One refreshing aspect of the *Mazankowski Report* was that it avoided the major pitfall of most provincial or national investigations of health care (most notably, Saskatchewan's Commission on Medicare, 2001; Romanow, 2003). It did not assume, *a priori,* that publicly-funded health care is the most cost-effective model or that it is necessarily the best way to make health care equally available to all. In fact, it called the system an unregulated monopoly and pointed out several problems with such a system, including that there is no competition and, therefore, no incentive to provide the most efficient and effective services available. Individuals dissatisfied with the care they receive can't "take their business elsewhere," so there is no incentive to keep improving service unless it is to save money (Premier's Advisory Council on Health, 2001).

International evidence supports the understanding that, with regards to cost-effectiveness, Canada's system is not the best model. A country such as Singapore, for example, manages to provide care at a lower cost than Canada but has comparable health status. A glance at World Health Organization or OECD data shows that, in terms of health status measures such as life expectancy, self-reported health status, and mortality rates, Canada fares relatively well internationally, but not always the best. The same international sources of data also show that, in terms of cost, Canada's system is expensive when compared with other countries in the world. A recent Fraser Institute study showed that Canada has the highest age-adjusted spending on health (a distinction shared with Iceland) among OECD countries with universal access health care systems, but that Canada does not rank first in any elements of access to care, supply of technologies, or number of physicians, and ranks first in only one element of health outcomes (Esmail and Walker, 2004).

An Atlantic Institute for Market Studies report evaluated the growth of gross domestic product (GDP) and health expenditures in Canada and the United States from the 1970s to the late 1990s (Ferguson, 2001a). It also looked at the deficits being run by Canadian governments. The results are interesting. It is often claimed that the costs of health care in Canada were prevented from escalating uncontrollably—as they supposedly did in the United States—because of the introduction of medicare in the late 1960s. One observation of the AIMS study is that, had Canada's economic growth been as weak as US growth through the 1970s and 1980s, for those decades Canada's expenditures on health as a percent of GDP (national health spending/national income) would have been the highest in the world. This situation would have changed only in the 1990s, when Canada's growth rate became weaker than that of the United States.

Ferguson concludes that the introduction of medicare in Canada happened during a period in which the Canadian economy outperformed the US economy in terms of real growth rate. Therefore, Canada's apparent success at controlling health care costs until the 1990s was "illusory. Simply put, the introduction of medicare did not introduce a period of, or efficient mechanism for, health care cost control. When it came to the question of how much of our national income we were spending on health, we weren't particularly good, we were just lucky" (Ferguson, 2001a).

As to why it seems that the current system is so cash-strapped, Ferguson notes that the real per capita health spending by the public sector almost matches the whole real per capita deficit of all levels of government from 1970 to 1997. This suggests "that politicians of the day didn't want to risk facing us with the tax increases that would have been necessary if we were to support not just the health care system, but the whole edifice

of public expenditure without running up a hefty debt. Arguably, we put the whole of the Just Society on the national credit card" and now we are trying to pay it off (Ferguson, 2001a).

With respect to the claim that a publicly funded system is the most equitable, there are numerous problems with this statement, too. There is a lot of evidence showing that, despite the intention of medicare to be equitable, lower income Canadians do not have as much access to services, nor as good survival rates, as higher income Canadians (for examples, see Canadian Institute for Health Information, 2003a; Blendon *et al*., 2002; Canadian Institute for Health Information, 2002; Gratzer, 2002; McMahon and Zelder, 2002; Dunlop, Coyte, and McIsaac, 2000).

As well, Canada is not the only country in the world that values universality. In terms of access to care, *all* industrialized countries have measures that attempt to ensure that their citizens receive health care when they need it, regardless of their ability to pay. Conversely, no system has successfully eliminated inequalities in health status across socioeconomic or racial groups. In Canada, Australia, and other countries, there are significant inequalities in health status between certain groups (Ramsay, 2001).

There is nothing inherent about the Canada Health Act principles of universality, comprehensiveness, accessibility, and portability that require exclusive public funding of medically necessary services. In its conclusion, the Premier's Advisory Council on Health for Alberta states that it believes its recommendations are consistent with the spirit and intent of the act: "At the same time, if actions are not taken to make changes in critical areas and sustain the health system, it is highly likely that pressures will mount to look for new options outside the limitations of the Canada Health Act. That may not be our preference, but we also acknowledge that Albertans and Canadians will not accept continued rationing of health services, long waiting times, and denied access to new treatments and technology available elsewhere. The challenge is ours to meet" (Premier's Advisory Council on Health, 2001).

Section 5: The Public-Private Mix in Other Countries

All industrialized countries have mixed health systems in which both the public and private sectors contribute to financing medically necessary health care. Table 5.1 provides an overview of the market mechanisms that are in place in various countries. Even the United Kingdom, the system upon which Canada's was based, permits a parallel private health care system that offers the same services as those provided by the public sector, and allows its residents to buy insurance and/or any medical service from private insurers and health providers.

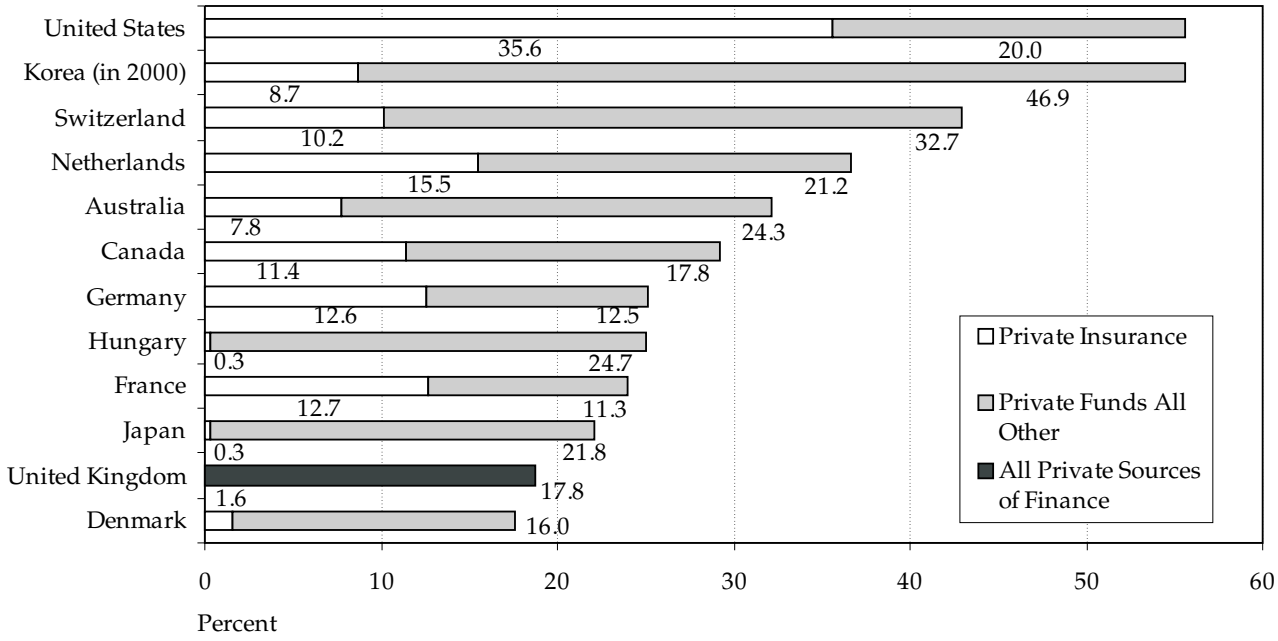
Basically, every industrialized country permits private health care delivery and financing. In Canada, for example, most doctors are independent, private practitioners who provide services to their patients and then are paid on a fee-for-service basis by the government. Also in Canada, residents must pay for all or a portion of the services not considered "medically necessary," such as pharmaceuticals, and care from alternative medicine practitioners (eg., chiropractic and naturopathy). Canadians can also purchase private insurance to cover the costs of some of the services not covered by the public sector. Canada's share of private financing is substantial, at 30.1 percent in 2003 (Canadian Institute for Health Information, 2003d). This places the country exactly in the middle of the 12 OECD coun-

Table 5.1: Market Mechanisms in Selected Countries

Country	User Fees[1]			Contracting Out of Services to Private Sector	Purchaser-Provider Split in Public System	Private Healt Insurers within Public System[2]	Private Health Care Complementary to Public System[3]
	GP	Specialist	Hospital (Inpatient treatment)				
Australia	Yes	Yes	No	Yes	No	n/a	Yes
Finland	Yes**	Yes**	Yes	Yes	Yes	n/a	Yes
France	Yes*	Yes	Yes	Yes	Yes	n/a	Yes
Germany	Yes**	Yes**	Yes**	Yes	Yes	Yes	Yes
Ireland	Yes*	Yes*	Yes*	Yes	No	n/a	Yes
Italy	No	Yes	No	Yes	Yes	n/a	Yes
Netherlands	No	No	No	Yes	Yes	Yes	Yes
Norway	Yes**	Yes**	No	Yes	No	n/a	Yes
Sweden	Yes*/**	Yes**	Yes	Yes	Yes	n/a	Yes
Switzerland	Yes*	Yes*	Yes**	Yes	Yes	Yes	Yes
United Kingdom	No	No	No	Yes	Yes	n/a	Yes

[1]Indicates whether the public system charges user fees for general practitioner (GP), outpatient specialist visits (Specialist), and inpatient hospital treatment (Hospital).
*Indicates that the particular user fees are waived for some groups of patients, usually based on income, age or health condition.
**Indicates that there is a maximum level of user fees that can be charged in a given period.
[2]In countries with social insurance models of health care financing.
[3]A private health system is complementary if one can obtain the same services within the private system as one could in the public system. Canadians would likely term this as "two-tier" health care.
Source: Irvine, Hjertqvist and Gratzer, 2002, with updates from Esmail and Walker, 2004.

Figure 5.1: Percent of Total Health Expenditure Financed by the Private Sector, by Source of Finance, 12 Selected Countries, 2001



Source: Canadian Institute for Health Information, 2003d.

tries in which private sector financing plays a role (figure 5.1). What follows is a brief description of the health care systems of some of these other countries. The purpose of the description is to generate discussion about potential models of reform for Alberta, as well as to provide context for the ideas that have been implemented or proposed in the province.

Australia

The government accounted for 67.9 percent of health expenditures in Australia in 2001 (OECD, 2003). Its Medicare program provides "free" treatment to Medicare patients in a public hospital and free or subsidized treatment for services that are considered "clinically relevant," such as consultation fees for doctors, most surgical and therapeutic procedures performed by doctors, and public hospital services. Medicare does not cover such things as dental exams and treatment, ambulance services, home nursing, physiotherapy, chiropractic services, glasses and contact lenses, hearing aids, prostheses, medicines, cosmetic surgery, and medical services that are not clinically necessary. In 2000, out-of-pocket payments accounted for 16 percent of total health expenditure (United Kingdom National Audit Office, 2003b).

For professional services provided in a hospital, the Medicare benefit is 75 percent of the schedule fee; for all other professional services, the Medicare benefit is approximately 85 percent of the schedule fee. Australians may insure privately for care in private hospitals, and they may insure with private insurance companies for the gap between the Medicare benefit and the schedule fee. Though physicians are free to charge a fee of their choosing, they can accept 85 percent of the

schedule fee only, and no co-payment, in return for billing Medicare directly, rather than the patients; nearly 80 percent of services are billed this way (Hilless and Healy, 2001).

Insurance premiums in Australia—public and private—are community rated. That is, health funds cannot discriminate against people by charging them differential premiums on the basis of their risk (age, sex, health status, and lifestyle). People can switch health funds without penalty.

The federal government's Lifetime Health Cover program takes into account the length of time that a person has had private hospital insurance (or cover) and rewards them by offering lower premiums. As well, the "Federal Government 30 percent Rebate" initiative refunds 30 cents for every dollar that people contribute to their private health insurance premium. Private insurance accounts for about eight percent of health care expenditure (UK National Audit Office, 2003b) and enrolment in private plans is approaching 45 percent of the population (UK National Audit Office, 2003b; Irvine, Hjertqvist, and Gratzer, 2002).

France

In France, all legal residents are covered by public health insurance, which is paid for from taxes and compulsory social health insurance contributions from employers and employees. Sickness insurance funds cover 99 percent of the population (UK National Audit Office, 2003b).

People are not permitted to opt out of the public system—there is no choice of insurer. However, most people have additional private insurance to pay for services not covered by public health insurance—mutual insurance funds cover about 80 percent of the population, meaning that, for most of the population, 100 percent of the cost of the majority of medical procedures is reimbursed. For ambulatory care, patients pay physicians' bills and are then reimbursed by sickness funds (UK National Audit Office, 2003b).

Inpatient care is provided in public and private hospitals. Physicians in public hospitals are salaried, while those in private hospitals receive fee-for-service payments. Within limits, some public hospitals are allowed to treat private patients, for which they receive a portion of the private fee.

There are patient contributions for ambulatory care (about 30 percent for GP and specialist visits), pharmaceuticals (ranging from 35 to 65 percent, for the most part) and 40 percent for laboratory tests (Conference Board of Canada, 2004; UK National Audit Office, 2003b). But France waives co-insurance payments for a long list of groups, including disabled children and pregnant mothers, as well as for people suffering from a specified list of expensive illnesses such as AIDS and diabetes (Gratzer and Irvine, 2002). Overall, out-of-pocket payments account for 10 percent of health care spending (UK National Audit Office, 2003b).

Germany

Germany has a statutory health insurance (SHI) system made up of competing sickness funds. Sickness funds are decentralized, self-administered, nonprofit organizations, and the funds are financed by equal contributions from employers and employees. The premiums are a fixed percentage of an employee's income and are not related to his or her age, sex, or health status. Contributions to the funds are subject to upper and lower thresholds.

About 88 percent of the German population belong to the SHI system. Those Germans with an income above a defined threshold are permitted

to opt out of the public system and purchase private insurance—about 9 percent of Germans have chosen this option—and only 0.1 percent of the population is not insured (European Observatory, 2000). Premiums for private health insurance are related to an individual's age, sex, and health status.

For insured persons, there are user fees for physician services, hospital and other services such as optician services, and dental care. Local public health offices provide some services free to everybody, regardless of whether they have insurance. There are co-payments required for pharmaceuticals and the government has a list of medications it subsidizes.

Most public hospitals are being privatized and, by 2015, it is expected that only a few hundred of Germany's 1,700 hospitals will remain under control of the government (Irvine, Hjertqvist, and Gratzer, 2002).

New Zealand

In 2002, the proportion of publicly funded health and disability support services accounted for around 77.5 percent of the total expenditure on health in New Zealand (OECD, 2003). Over the last two decades, the proportion of health expenditure financed privately has risen from 12 to 22.5 percent (OECD, 2003).

Most New Zealanders are eligible for publicly funded health and disability services. Eligible people may receive free inpatient and outpatient public hospital services, subsidies on prescription items, and a range of support services for people with disabilities. There is a fee-for-service system for primary care, although visits to the doctor and prescription items are generally free for children under age 6, and basic dental care for children is generally free until age 16. Most adults have to pay the full cost of their doctor visits and make a payment for pharmaceuticals. However, for people who have to make many visits, or who require a lot of medication, there is the possibility of getting a government subsidy. Individuals may also choose to use private health care services, but public hospitals are not permitted to treat private patients.

Singapore

In Singapore, private practitioners provide about 80 percent of primary health care, while government polyclinics provide the remaining 20 percent. For hospital care, the government provides 80 percent of the care and the private sector 20 percent (Ramsay, 2001). Patients are expected to pay at least part of the cost of the medical services they use—inpatient or outpatient—and to pay more if they demand higher levels of service in terms of comfort and amenities. Co-payments apply even to most heavily subsidized hospital wards. While no Singaporean is denied access to the health care system or use of emergency services at public hospitals, private hospitals are not required to accept all patients.

The main methods of health funding and insurance are organized through the government. Its philosophy is that Singaporeans should be encouraged to adopt healthy lifestyles and be responsible for their own health. To this end, it has devised three programs: Medisave, Medishield, and Medifund, and has recently added a fourth, called ElderShield. As well, it relies heavily on supply-side measures, such as limiting the number of physicians, specialists, and high-technology services, to control health costs.

Medisave is a compulsory savings scheme to help Singaporeans pay for any hospitalization costs they may incur, especially after retirement. It is part of the country's Central Provident Fund, a

fund into which both employees and employers contribute roughly the same amount (totalling 40 percent of an employee's income) for an employee's retirement, housing needs, and health care. The contributions are tax deductible and earn interest. Singaporeans can withdraw from their medical savings account to pay for their own hospital bills or those of their immediate family. They keep any amount remaining in their account at the end of the year.

Medishield is a voluntary insurance plan designed to help Singaporeans meet any medical expenses arising from a major accident or prolonged illness. Reimbursements are based on a system of deductibles and co-insurance, and there are claim limits per policy year and per lifetime. Medishield premiums are paid from Medisave contributions.

Medifund is an endowment fund set up by the government as a safety net to help low-income Singaporeans pay for their medical care. Anyone who is unable even to pay for subsidized hospital care can apply for help from Medifund. The new, low-cost insurance program ElderShield was introduced in 2002 to provide financial protection for individuals suffering from severe disabilities.

Around one-quarter of Singaporean health expenditure comes directly from the government budget; out-of-pocket spending represents about one-third of total health spending; employer medical benefits accounts for another one-third; and Medisave, Medishield and Medifund together contribute less than 10 per cent of total spending (Hanvoravongchai, 2002). When viewed in relation to the inpatient expenditures for which it is intended, the Medisave share is larger. Roughly 85 to 90 percent of hospital inpatients make use of their Medisave accounts to pay their hospital bills (World Bank 2003).

While the percent of total spending for which Medisave accounts may be relatively small, Medisave plans have been conducive to savings. At the end of 1999, there were more than 2.68 million Medisave accounts, Singaporeans had an average of about S$7,760 in their accounts and the total Medisave balance was S$20.8 billion—equivalent to more than four times the total national health expenditure that year, whereas net assets in Medisave in 1995 were worth only S$12.7 billion (Hanvoravongchai, 2002). A 1995 national survey of senior citizens indicated that Medisave had become the most important source of financing for acute care for the elderly over 55 years of age. However, a large proportion of elderly did not yet have enough funds of their own and had to depend on other sources, including their children's Medisave—although a higher proportion of the 55 to 64 year-olds who spent more time in the workforce could finance their health care from their own accounts than those in older age groups (Hanvoravongchai, 2002).

Sweden

In Sweden, the central government focuses more on the performance of the services and on results than on how the services are organized. There are 26 county councils in Sweden responsible for purchasing from hospitals and other providers the health care services needed for their populations of between 60,000 and 1.7 million people. Local authorities are responsible for the care of the elderly and disabled people in the places where they live.

Swedish residents are entitled to use health services at subsidized prices, but there are co-payments for primary health care, hospital stays, outpatient care, dental care, elderly care, and for prescription drugs. The fees vary by county, but, to limit the expenses incurred by patients, there is a high-cost ceiling. Certain population groups,

such as children, are exempt from patients' fees. User fees represent less than 2 percent of the total resources devoted to health care (Hjertqvist, 2002b).

In some counties, such as Stockholm, competition between service providers and private sector contractors has been encouraged. From 1992 to 1994, the Greater Council of Stockholm launched a number of competitive initiatives. With competitive contracting, the council reduced the yearly cost of ambulance service in the Stockholm region by 15 percent, laboratory costs fell by 50 percent, the cost of support staff services dropped by 30 percent, and privatized nursing homes reduced costs by 20 to 30 percent (Irvine, Hjertqvist, and Gratzer, 2002; Hjertqvist, 2001c). As well, there is evidence that, with competition, providers are offering a better service and are spending more time with patients; waiting lists have been reduced by more than 70 percent (Hjertqvist, 2001a).

Seven emergency hospitals in the Stockholm region serve almost two million people. Since 1999, one of them has been privately owned: St.Goran's Hospital, which realized a savings of 15 to 20 percent over the average of the publicly run hospitals (Irvine, Hjertqvist, and Gratzer, 2002). In 2000, two hospitals turned themselves into publicly-owned companies with formal business structures, financial statements, and a board of directors; at least two of the remaining ones plan to do the same (Hjertqvist, 2001c).[13]

With the help of the council, some 100 health care units are in the process of leaving public ownership to become private companies. New contractors run local health care centres, GP group practices, treatment centres for mothers and infants, laboratories, and psychiatric out-of-hospital clinics. When (and if) the council completes this transformation, private GPs and other contractors will deliver around 40 percent of all health services, and about 80 percent of all primary health care in the metropolitan area (Hjertqvist, 2001c).

In the Swedish health care system, recruitment has been a problem, due to low birth rates and the poor image the system has as a place to work. Private sector advances have allowed for better working conditions, higher wages for many, and there are providers who have started up their own enterprises. The National Union of Nurses, with 120,000 members, actively supports nurses who want to leave the public sector and begin working as contractors (Hjertqvist, 2001c).

Switzerland

According to the Organisation for Economic Co-operation and Development, public expenditures accounted for 57.1 percent of total health care spending in Switzerland in 2001 (OECD, 2003).

It is compulsory for Swiss citizens to have sickness insurance, but the public and private sectors share the insurance market. Insurance companies are prohibited from refusing anyone coverage and there is a basic set of benefits that insurers must cover by law. As well, based on the required set of benefits that insurers must offer, insurers within each canton must pay a portion of their premiums into a regional fund so that, in effect, the insurers with healthier members subsidize those with less healthy members.

13 Early this year, despite evidence to the contrary, the Swedish government banned further privatization of hospitals claiming that the expansion of private care could destroy the principle of a fair and free public health service (Burgermeister, 2004).

Insurance premiums are based on actual costs and do not include income as a factor; and they differ by region. Those citizens who cannot afford the health insurance premiums receive an income supplement (not a health premium subsidy) from the canton. There are deductibles and various cost-sharing arrangements in Switzerland for physician, specialist, hospital, and other health services. Patients must pay the first $112 US of medical expenses out of pocket, followed by co-insurance up to a yearly maximum –although private insurance is legal, citizens may not insure themselves against the deductible (Gratzer and Irvine, 2002).

United Kingdom

The National Health Service (NHS) is based on the ideal of universal coverage for all British citizens, paid for from general tax revenues. But initial cost estimates for the NHS were soon exceeded and fees were added for such services as prescriptions and dental care. (Today, however, 85 percent of prescriptions are dispensed to people who are exempt from the charges (UK National Audit Office, 2003b; British Medical Association, 1999.)) Additionally, the United Kingdom has always had a private health care system that operates parallel to the public system (i.e., that provides acute, long-term, and other types of care). While the NHS insures everyone, people are permitted to buy insurance from private insurers and/or any medical service from private health providers, and about 11.5 percent of the population have done so (UK National Audit Office, 2003b).

Reforms in the 1990s created an internal market in health care. NHS trusts are semi-autonomous bodies with responsibility for the ownership and management of hospitals. Primary care trusts (PCTs) have been formed from what were known as GP fundholders. The PCTs include GPs, other health professionals, social services, and members of the local community: they have their own budgets for the health care of their population—at least 100,000 people per trust (Ramsay, 2001). As an incentive to make efficient allocation decisions, trusts and PCTs are allowed to retain any financial surpluses (Irvine, Hjertqvist, and Gratzer, 2002).

The NHS trusts are the providers of services, and the health authorities and the PCTs are the purchasers of those services. The "internal market" required providers to compete with each other, on the basis of quality and price, to attract purchasers, which were now permitted to contract with providers outside of their regions. The Adam Smith Institute estimates that contracting out reduces costs by about 20 percent (Irvine, Hjertqvist, and Gratzer, 2002).

Section 6: The Potential Role for the Private Sector

Some areas of health care seem to fall naturally under the purview of the public sector. For example, it would be difficult for the private sector to provide enough public health and communicable disease management services, yet these services are important in that they have been shown by more than one study to have a net positive social benefit. However, as discussed above in earlier sections, the argument for the sole provision and financing by the public sector of many other services, such as acute care, is less credible. This is why most countries have a mixed public-private system, in which the private sector is allowed to provide and finance all that which the public sector provides and finances.

People choose to use private health care for various reasons, even if the same goods and services are provided by the public sector for a lower direct cost to patients. Given the multiplicity of demands on public sector budgets and, therefore, the need to ration care (using wait lists or only

Table 6.1: Spectrum of Public-Private Partnership Options

Model	Options
Privatization	• Privatization/Divestiture involves the sale or divestiture the assets and operations of a public facility to a private sector entity • Build-Own-Operate (BOO) is where the private sector finances, builds, owns, and operates a new facility in perpetuity
Concession	• Build-Operate-Transfer (BOT) or Build-Own-Operate-Transfer (BOOT) is where a private developer receives a franchise to finance, build, and operate a facility (and to charge user fees) for a specified period, after which the assets are transferred back to the public sector. The ownership of the assets can either be continuously by the public sector or shared under a lease. If the assets are owned by the private developer for a time then returned to the public sector, then it's a BOOT • Design-Build-Finance-Operate (DBFO) is similar to the BOT model, but includes design by the private partner • Concession Lease (*strictu sensu*) is when a private operator, under a long-term lease, expands and operates an existing facility • Concession Lease (*affermage*) resembles the Concession Lease (*strictu sensu*), except that the private sector operator has no obligation to make capital improvements to the public facility • Corporatization is where the public sector transfers an asset to a quasi-public authority under sale or lease, together with a contract that the authority will perform public services using private procedures and financing • Build-Transfer-Operate (BTO) is when a private developer designs, finances, and constructs a facility which, upon completion, is transferred to public ownership. The public partner then leases the building back to the private partner to operate • Lease is where a private partner leases existing public infrastructure assets, and operates the assets and the business at its risk for a finite term
Operations and Maintenance	• Operations and Maintenance Contract (O&M) comprises a private operator, under contract, operating a publicly owned facility for a specified amount of time • Service Contract is when a private operator provides outsourced services of a commodity nature to the public sector, such as housekeeping, laundry or dietary services

Source: Canadian Council for Public Private Partnerships, 2003.

subsidizing certain goods and services), some people will look to the private sector for faster access to care, more choice in goods and services, and the expectation of higher quality: "the relatively high use of private providers by people of all economic levels in most countries indicates qualitative differences perceived by users, not just a lack of resources" (Rosenthal and Newbrander, 1997).

As is evidenced by the experience in Alberta and in other parts of the world, there are many ways in which the private sector can be involved in health care. Under the Canada Health Act, the private sector may be involved in the delivery of health care, so the contracting out of surgical services to private facilities is allowed, as is the contracting out of other health and support services. As well, in several provinces, the private sector is being considered as a partner in the design, construction, financing, and even operation of hospitals. This is what most people mean when they talk of public-private partnerships, or P3s, even though this is only one type of P3. Contracting out also represents a public-private partnership, as does a private hospital that provides services to public patients or the government, albeit these two options lie at opposite ends of the P3 spectrum (table 6.1).

On the demand side, publicly insured, medically necessary goods and services are free at the point of service and provincial governments have laws prohibiting private payment or insurance for these goods and services, while the Canada Health Act uses financial penalties against provinces that permit extra billing by doctors or user fees by hospitals. For completely uninsured services, such as many complimentary medicines and therapies, people must bear the entire cost themselves. In the middle of these two scenarios is a range of health services insured by the private sector (dental care, for example) and the public sector (pharmaceuticals, for example) that involve cost-sharing mechanisms such as user fees, deductibles, and co-payments, requiring individuals to "share" the cost of these goods and services with the insurer (public or private).

Alberta's public health care system suffers from waiting lists, emergency room back-ups, a lack of high-tech medical equipment, less access to newer pharmaceutical treatments, and provider shortages. Despite the scarcity of resources, there is a constant emphasis on the need to contain costs and making the system sustainable. But it is because health care in Alberta is organized, for the most part, as a sole function of government that increasing health care costs are problematic. Not only could the private sector help relieve some of these pressures, it could contribute greatly to the economy, as there is an abundance of well-paid and interesting employment opportunities in the health care sector (Premier's Advisory Council on Health, 2001; Ramsay and Walker, 1996).

Currently, Alberta has many private health care providers who supply everything from support services, to diagnostic services, to surgeries. But, in the "big ticket" area—acute care—which absorbs almost 39 percent of government spending on health, most of the funding comes from the government. In Alberta, the private sector accounts for less than seven percent of total hospital spending (see table 3.5 for dollar figures). Cost pressures and the need for new infrastructure have caused governments across the country, including that of Alberta, to try and increase this proportion. Two of the main ways of doing this are public-private partnerships based on one of the concession models described in table 6.1, and permitting private hospitals. While the latter is currently prohibited in Alberta, both options are examined below.

P3s for the design, construction and financing of hospitals

A public-private partnership is an arrangement for the provision of infrastructure or services that is based on the idea that each sector has inherent expertise that, if combined, will maximize the quality of the final service provided to the public, through the most appropriate allocation of resources, risks, and rewards. In P3s, the public sector maintains an oversight and quality assessment role, while the private sector is more closely involved in actually delivery of the service or project (Industry Canada, 2003).

According to groups such as Friends of Medicare, P3s are a serious threat to the future of the public health care system and must be stopped. "In these hospitals, for-profit corporations take over key hospital services, and run them for their own gain," said Harvey Voogd, coordinator for Friends of Medicare (United Nurses of Alberta, 2004b). He was quoted in the United Nurses of Alberta's March 9 edition of *UNA Stat*, in the context of a recent cooperative effort by several groups in a nation-wide campaign to get the federal government to block public-private partnerships in Canadian hospitals (United Nurses of Alberta, 2004b).

While there are reasons to be cautious about P3s, a review of the literature in this area found it is not unusual to find reported savings (improved value-for-money) to the public sector of 20 percent or more relative to traditional procurement, which allows for increased availability of social infrastructure and more public funds for other budgetary needs (Allan, 1999/2000). International experience indicates that P3s could result in more creative facility designs, cost savings, and lower lifecycle costs of 20 to 30 percent (Canadian Council for Public-Private Partnerships, 2003). In the United Kingdom, the introduction of the Private Financing Initiative (PFI) process has reduced cost and time overruns of construction (Canadian Council for Public-Private Partnerships, 2003; United Kingdom National Audit Office, 2003a). Among its many recommendations for reform, the Kirby Commission, one of the more recent national reports on health care, stated that: "The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity" (Standing Senate Committee on Social Affairs, Science, and Technology, 2002b).

Potential problems with P3s include governments not properly enforcing contractual arrangements and governments contracting with the private sector without considering competitively priced public ventures (Commission on Public Private Partnerships, 2001). There have been examples of poor procurement practices, in which there has been only one bidder on a project and competitive tension is not maintained, as well as a tendency for government departments to bail out PFI contractors who get into trouble (United Kingdom Parliament, 2003c). Another major concern has been a lack of transparency as to whether the total returns that construction companies derive from PFI projects are reasonable in relation to the risks the companies are actually bearing (UK Parliament, 2003b).

Despite the potential flaws of the PFI, since the program started in 1992, it has become one of the main methods by which the public sector in the United Kingdom procures services from the private sector. As of June 2003, more than 500 deals had been signed with a total capital value of more than £50 billion (UK Parliament, 2003c). With respect to the National Health Service specifically, 64 projects worth more than £9.5 billion are now underway or being contemplated; plans for infra-

Table 6.2: Potential Generic Benefits and Drawbacks of the Private Finance Initiative (P3s) in the United Kingdom

Potential Benefits	Potential Drawbacks
There can be greater price certainty. The department and contractor agree on the annual unity payment for the service to be provided. This should usually only change as a result of agreed circumstances.	The department is tied into a long-term contract (often 30 years). Business needs change over time so there is the risk that the contract may become unsuitable for these changing needs during the contract life.
Responsibility for assets is transferred to the contractor. The department is not involved in providing services that may not be part of its core business.	Variations may be needed as the department's business needs change. Management of these may require re-negotiation of contract terms and prices.
PFI brings the scope for innovation in service delivery. The contractor has incentives to introduce innovative ways to meet the department's needs. In the case of hospitals, however, this is limited since currently clinical services are excluded and remain with the National Health Service Trust.	There could be disadvantages, for example, if innovative methods of service delivery lead to an unintended decrease in the level or quality of service.
Often, the unitary payment will not start until the building is operational, so the contractor has incentive to encourage timely delivery of quality service.	The unitary payment will include charges for the contractor's acceptance of risks, such as construction and service delivery risks, which may not materialize. (This is not necessarily a disadvantage, simply appropriate compensation for the contractor agreeing to take the responsibility for any potential problems.)
The contract provides greater incentives to manage risks over the life of the contract than under traditional procurement. A reduced level or quality of service would lead to compensation paid to the department.	There is the possibility that the contractor may not manage transferred risks well. Or departments may believe they have transferred core business risks, which may not materialize. (This is not necessarily a disadvantage, simply appropriate compensation for the contractor agreeing to take the responsibility for any potential problems.)
A long-term PFI contract encourages the contractor and the department to consider costs over the whole life of the contract, rather than considering the construction and operational periods separately. This can lead to efficiencies through synergies between design and construction and its later operation and maintenance. The contractor takes the risk of getting the design and construction wrong.	The whole life costs will be paid through the unitary payment, which will be based on the contractor arranging financing at commercial rates, which tend to be higher than government borrowing rates. (In Canada, many hospitals are independent legal entities and, in most cases, cannot themselves borrow funds as cheaply as the relevant provincial government; value-for-money studies indicate that the slight increase in interest rates borne by the private sector is a relatively small factor in the life-costing of a project and may be completely offset by risk assumption, efficiency, and other value added by a private partner; and the experience in the UK has been that the risk-adjusted cost of private capital is less than the public sector comparator and that the premium for private capital has been decreasing (Canadian Council for Public-Private Hospitals, 2003). Further, the government's interest advantage over the private sector is often exaggerated because the tax deductibility of interest payments is overlooked; PricewaterhouseCoopers adds that the objective of a P3 is to provide best value for money, the "optimal combination of quality and timeliness of services provided, and cost,," meaning that the lowest cost is not necessarily the best value (Esmail, 2003b).)

Source: United Kingdom National Audit Office, 2002, unless noted otherwise.

structure renewal include the building of 100 new hospitals by 2010 (Canadian Council for Public-Private Partnerships, 2003). The United Kingdom has vast experience in public-private partnerships. Table 6.2 lays out the main potential benefits and drawbacks of P3s, or the PFI.

In Canada, New Brunswick, Alberta, Ontario, Nova Scotia, and, more recently, British Columbia and Quebec are adopting P3s as a way to improve service efficiencies and delivery with limited government resources (Industry Canada, 2003). While there have been few ventures involv-

Table 6.3: Opportunities for Private Involvement in Hospital Capital and Operations, Based on Operating Spending in Ontario Hospitals

	Area of Opportunity for Involvement by the Private Sector	Average % of Ontario Hospital Operating Budget (Including the Implied Cost of Capital)
Clinical Services	Clinical Care Delivery	54
	Diagnostic/Lab	5
	Pharmacy	4
	Medical Technology	2
	Information Technology	4
	Support Services	10
	Dietary	3
	Facility Management/ Maintenance	3
Infrastructure	Building	15

Source: Canadian Council for Public Private Partnerships, 2003.

ing hospitals, Canada has undertaken a number of P3 projects, including, but not limited to, the Confederation Bridge construction; Ontario's Highway 407; airports in Toronto, Vancouver, Hamilton, and Moncton; water services in such places as Canmore, Edmonton, Port Hardy, Halifax, and Winnipeg; Cornwall's electric system privatization; and hospital services and buildings in Richmond, Vancouver, Ottawa, and Brampton (Industry Canada, 2003).

Based on the international and national experience with P3s and 10 specific case studies, including the East Coast Forensic Hospital in Nova Scotia and the Royal Ottawa Health Care Group, the Canadian Council for Public Private Partnerships (2003) concludes that the design-build-finance-operate (DBFO) model has the most merit for Canada, that it best allocates resources, risks, and rewards. The council proposes that Canadian hospital P3 pilot projects be developed to test, refine, and adapt the P3 model for broader implementation. This would entail the development of an appropriate financing model, including any legislative reforms and a methodology for evaluating and allocating risk, as well as several other steps, including the identification of "champions" of the idea in the hospital sector (Canadian Council for Public Private Partnerships, 2003).

While P3s for the design, construction, finance, and operation of hospitals may be the best option under the Canada Health Act, there are more potential gains from the outright privatization of hospitals or the permitting of private hospitals. Table 6.3 shows the opportunities for private involvement in hospital capital and operations based on operating spending in Ontario. The data in the table include the implied cost of capital (whole life costing). In the current funding model in Ontario, capital contributions are expensed in the year of funding and so are not amortized or otherwise reflected in annual operating costs (Canadian Council for Public Private Partnerships, 2003).

There is much more potential for involvement by the private sector—and, therefore, for the benefits that it can bring to the hospital sector—in the clinical services area, which represents 54 percent of operating costs, versus other areas, such as diagnostics (five percent of the budget), support services (10 percent) and building (15 percent). This is why the issue of private hospitals should not be dismissed, despite current legislation.

Private hospitals

There is a substantial quantity of literature on the relationship between hospital ownership—private versus public, not-for-profit versus for-profit—and health care costs and outcomes. In general, the literature indicates that for-profit and not-for-profit hospitals are equally efficient,

but that there are distinct efficiency advantages in relying on private hospitals vis-à-vis publicly owned hospitals. The Canadian paradigm has thus far been reliance on the latter and an abject fear of the former.

Two large reviews of the literature on private versus public hospitals can provide some insight into the general findings. A summary published by the Government of Alberta found eight studies that gave evidence on the benefits of private hospitals relative to publicly operated hospitals (Government of Alberta, 2000). One study showed that higher administrative costs do not necessarily lead to increased overall costs, and gave evidence that private for-profits "had the lowest increase in Medicare operating costs per case in every year since 1991"; five studies indicated that government hospitals tended to be less efficient than private hospitals, even in rural areas; and two studies found that private hospitals outperformed public hospitals in terms of various performance measures. Zelder (2000a), while examining these eight studies and a further seven that showed contrary findings, concluded that, on the whole, "the economics literature on the effects of hospital competition in the US reveals that, over the last 10 years, competition has been unambiguously beneficial, lowering cost and increasing quality" (Zelder, 2000a).

There is also a substantial body of evidence demonstrating that the ability to retain profits will not necessarily result in a lower standard of care. Hsia and Ahern (1992) concluded that not skimping on care under a prospective payment regime would produce significantly higher profits. Cleverly and Harvey (1992) concluded, using a small sample of hospitals, that poor quality hospitals (hospitals with higher mortality rates) were less profitable. Tomal (1998) found that higher prior-year profit margins in both for-profit and not-for-profit hospitals were associated with lower hospital mortality rates. Clearly, the profit motive is not necessarily a source of reduced quality care.

For-profit hospitals have also been known to reinvest profits from operations rather than pay out profits as dividends to shareholders (Graham, 2002). These for-profit hospitals in the United States also hold more capital and fewer financial investments than do public hospitals in Canada (Graham, 2002), echoing findings that government business enterprises tend to be under-capitalized (Megginson and Netter, 2001).

International experience also suggests that private delivery of health services would be beneficial for residents of Alberta. As discussed in section 5 above, St. Goran's Hospital in Sweden was privatized three years ago and has realized savings of 15 to 20 percent over the average of the publicly run hospitals. In Stockholm, several other hospitals are about to be privatized and some 100 health care units are in the process of leaving public ownership to become private companies. Contractors run local health care centres, GP group practices, treatment centres for mothers and infants, laboratories, and psychiatric out-of-hospital clinics. Before this process began, recruitment had been a problem, but private sector advances have allowed for better working conditions and higher wages for many.

As well, "cherry-picking" by private providers is not something to be feared by either taxpayers or patients. The fact that private providers may have an incentive to cherry pick (serve less ill patients) can, in fact, be beneficial for health care delivery. In New Zealand, private health providers tend to focus on the relatively common, less invasive, and simpler procedures, allowing public providers to focus on more difficult and costly care (French *et al*., 2001).

Finally, private providers, because of their incentives to increase efficiency and provide a higher level of care in order to attract more patients, will end up enhancing care for all patients, including the very poor. Evidence from the United Kingdom has shown that the lower socio-economic classes benefited the most from the private sector's involvement in hospital care provision (McArthur, 1996).

The privatization of hospitals cannot, however, be done without the introduction of competition. As Ferguson notes: "[p]rivate clinics will produce socially desirable results only when they are introduced into a competitive environment" (2002). Without competition between health care providers, most of the incentives to improve both cost performance and quality of care will be lost.

The demand side—cost sharing

When individuals do not face any charges for health services (i.e., a third party—the government or a private insurance company—covers their medical expenses), they have no incentive to restrain their health care use. Such a situation can produce excessive demand for care and result in wasted resources, to the extent that the costs of producing these services exceed what individuals would be willing to pay for them. This phenomenon is known as "moral hazard." (See "Insurance" in section 2 above.)

Co-insurance, deductibles, and co-payments are commonly used to control excessive use due to under-valuation of insured consumption, and have a number of advantages. The first is that they increase efficiency in the health delivery sector and reduce costs: if required to bear a portion of health care costs, individuals will curb their consumption of medical care, and medical services of lesser value will eventually be eliminated. A second advantage is that these payments can reduce the tax burden of Canadians because they redirect health care financing from taxpayers to users.

Evidence from the RAND health insurance experiment (Newhouse *et al*., 1993), discussed in more detail below, suggests that even modest user fees have an impact. The RAND experiment found that the largest drop in health care consumption resulted from a shift from a free plan to a 25 percent coinsurance plan. And, in Europe, coinsurance rates range between five percent and 40 percent, while co-payments for GPs range between $12 US and $32 US (Gratzer and Irvine, 2002).

Unfortunately, cost sharing can have an adverse effect on the health of the poor and the sick poor. According to the RAND experiment, the health of this segment of the population is severely affected by cost-sharing—both mortality rates and high blood pressure worsen among high-risk individuals. For this reason, any cost-sharing program must either completely exempt low-income individuals, the chronically ill, and others found to be adversely affected by the program, have differential rates and/or caps for these groups, exclude certain procedures from user fees (for example, immunization, mammograms or flu shots), or in some other way include a safety net.

Costs and benefits of a cost-sharing program

Since international experience shows that user fees reduce demand for services, encourage patients to use health services more appropriately, and give people a better understanding of the cost of health care, they are an idea worth exploring.

The concept is not as simple as charging a fee, as most countries put a limit or cap on the amount of out-of-pocket payments people must pay. So,

while a large user fee or co-payment may deter use, it also has the effect of getting individuals to the cap more quickly. Once the threshold has been reached, health care is free at the point of service for the individual and the incentives are akin to that of free care, which can negate the desired effects of the user fee.

As well, the exact structure of the user fee is debatable since each type of patient cost sharing has its advantages and disadvantages. Co-payments are the easiest to understand and implement but, although deductibles are not commonly used in other universal health care systems, they could play a role in Canada. One advantage of a relatively small deductible, say of a few hundred dollars, is that it can have the effect of discouraging the use of low-valued services, while having no effect on more expensive services (Gratzer and Irvine, 2002).

Skinner (2002) applies the findings of the RAND experiment to an analysis of individual use of medicare for the entire population of Nova Scotia (almost one million people). He shows that the introduction of a $325 deductible for the use of physician services (equal to the average annual per capita usage of physician services), combined with publicly subsidized medical savings accounts (MSA) for low-income individuals,[14] would reduce overall demand on the provincial health system by a minimum of 4.6 percent, without any expected adverse health outcomes. By transferring the costs from taxpayers to users, the introduction of the deductible would have resulted in net savings of $88.3 million in 2002, after taking into account the costs of implementing such a program. According to Skinner, if one assumes a roughly similar distribution of the use of physician services across the rest of the country, Canada could have saved over Cdn $2.7 billion on health care in 2002.

Looking at the costs and benefits of a hypothetical cost-sharing program in Alberta, there would be extra financial costs to patients, but these would have to be measured against the greater ease of access that would result from such a program. As well, there is potential for immense financial gains for both the provincial government and taxpayers if such a program were to be implemented. Before calculating these potential gains, it is first necessary to briefly outline some of the details of the RAND health insurance experiment, which is the seminal study on the effect of cost sharing.

In the early 1970s, researchers at the RAND Corp., which is based in Santa Monica, California, began an experiment that encompassed approximately 2,000 non-elderly families (no participant was over the age of 65) and 14 different insurance plans. They found that a 25 percent coinsurance rate (where patients are responsible for 25 percent of the cost of treatment up to a maximum annual charge) would cost 19 percent less overall than a "free" plan (a health plan with no cost sharing for services—a "Canadian" style program). Increasing that coinsurance rate to 95 percent increased the savings to 33 percent (Newhouse *et al*., 1993).

On the whole, this charge for health services resulted in little or no net adverse effect on patient health. Patients, on average, experienced no significant differences in the risk of death or measures of pain and worry. In fact, the most important determinant of health at the end of the experiment was typically health at enrolment (Newhouse *et al*., 1993). Only low-income indi-

14 In his analysis, Skinner (2002) defines low-income consumers as those whose household income is below the federal GST cut-off of Cdn $32,000.

Table 6.4: Optimistic/High Estimate of Savings of a Cost-sharing Program in Alberta (2001)

Total Health Expenditures ($ millions)[1]	Savings (19%)	Estimated Total Expenditures with Reform ($ millions)	Estimated Patient Expenditures (16% of total with reform)
$7,030.43	$1,335.78	$5,694.65	$911.14

[1]Total provincial government expenditures on health care.
Source: Canadian Institute for Health Information, 2003d; Newhouse *et al.*, 1993. Calculations by authors.

viduals with particular pre-existing conditions (high blood pressure, vision problems, and bad teeth and gums, as well as anaemic children living in low-income households) experienced better outcomes when provided free access to care (Newhouse *et al.*, 1993). Thus, evidence from the RAND experiment supports the conclusion that, as long as an exemption is in place for the poor, a cost-sharing program will not have an adverse effect on health or result in increased long-term expenditures because of individuals delaying treatment.

These findings suggest that Albertans would benefit immensely from a cost-sharing program. First, access to family physicians and clinics would be improved for those in need, as some patients will opt to avoid the expenditure and not seek medical attention. Second, long waiting times for emergency care would fall, as patients requiring attention for non-critical conditions would seek care elsewhere. Third, resources freed up as a result of these first two effects could be used to treat the more serious health problems that reside on the provinces' waiting lists. In the longer run, these savings could also make room for much needed tax relief (Clemens and Veldhuis, 2004).

How large would these savings be? An optimistic estimate for the year 2001 (the most recent year for which the Canadian Institute for Health Information provides spending per capita by various age groups), can be calculated by applying the 25 percent co-payment and 19 percent savings to the entire population of Alberta. The savings in this scenario would be approximately $1.34 billion (table 6.4). Of the amount remaining after deducting the savings from total expenditures, the provincial government would pay 84 percent, or $4.78 billion, while patients would pay $911 million, or 16 percent. Note that the costs shifted to patients are substantially less than the 25 percent coinsurance rate. According to the RAND study, just under 21 percent of patients exceed reasonable maximum expenditure limits annually, leading to an average cost-sharing rate of 16 percent in the plan estimated for Alberta (Newhouse *et al.*, 1993).

This estimate is considered to be the "high" estimate of savings. As noted above, the RAND results suggest that low-income individuals with certain pre-existing health conditions should not be included in a cost-sharing program. Further, the RAND experiment did not include any people over age 65 because of the government insurance program (Medicare) in the United States that covers all such individuals. Thus, a "low" savings estimate is developed below, which includes exemptions for specific groups and reductions in savings for others.

The "low" savings estimate given below in table 6.6 is developed from the following assumptions.

Table 6.5: Representative Families and Basic Needs Thresholds

Family Type	Income Limit for Exemption[1]
Unattached Individuals	$9,001
2 Parents, 0 Children	$14,124
2 Parents, 1 Child	$17,166
2 Parents, 2 Children	$19,940
1 Parent, 1 Child	$14,124
1 Parent, 2 Children	$17,166

[1]Family income must fall below this value in order to qualify for an exemption.
Sources: Sarlo, 2001; calculations by authors.

1. **Low-income Albertans are exempted from the cost-sharing program.** The exemption estimates were done using six representative families (making up 85 percent of the Alberta population) and six distinct basic needs income thresholds (the income required to meet the basic needs of a family) (Sarlo, 2001a). Table 6.5 lists the six representative families and the basic needs income thresholds. The number of individuals, by age, exempted using these thresholds and representative family structures was then used to estimate the total number of individuals in each age group who would be exempted from the co-payment requirements in Alberta.

2. **Individuals aged 75 and over were completely exempted from the cost-sharing program.** According to the Canadian Institute for Health Information, health expenditures in Canada tend to rise dramatically as individuals advance in age (Canadian Institute for Health Information, 2003d). Further, precise estimates on the effect of cost sharing for the aged from the RAND health insurance experiment are unavailable because of the insurance structure in the United States. For these reasons, the low savings estimate simply assumes that all health services will be made available to these individuals without co-payment—as is presently the case in Alberta.

3. **Expenditures on hospital care are exempted from the cost-sharing program for children (aged 0-14) and adults aged 65-74.** For children, the probability of using inpatient hospital care in the RAND experiment was not sensitive to the amount of cost sharing required by the insurance plan, while other forms of care were responsive (Newhouse *et al*., 1993). For this reason, expenditures on hospital care were not included in the "low" estimate. Hospital care accounted for 83 percent of total health expenditures for those less than one year old, 24 percent for those aged one to four, and 16 percent for those aged five to 14.

   With regards to those aged 65-74, age distributions of spending show a clear U-shaped relationship for health expenditures over an individual's life: the very young and the very old tend to consume more health care, on average, than those in between (Canadian Institute for Health Information, 2003d). Inpatient care also has several other important characteristics:

   - The effect of age on inpatient hospital care tends to be significant in studies of health care use (Sine, 1994).
   - The demand for inpatient care is theoretically less responsive to cost sharing, and has been proven to be so for children (Sine, 1994; Newhouse *et al*., 1993).
   - Fifty percent of total health expenditures on individuals in the 65-74 age group are the result of expenditures on hospital care (Canadian Institute for Health Information, 2003d).

Thus, hospital expenditures on those aged 65-74 have been exempted from cost sharing in the "low" savings estimate. However, other health expenditures for those aged 65 to 74 were not exempted. Though RAND does not give estimates of changes in demand for increases in patient responsibility, a similar experiment in China suggests that all health expenditures for those over the age of 60 are less sensitive to cost sharing than for adults under the age of 60, but are more sensitive to cost sharing than health services for children (Newhouse *et al*., 1993; Sine, 1994). It is assumed that the exemption of hospital expenditures accounts for the differences in sensitivity to cost sharing between these age groups.

All groups of expenditures not specifically exempted above are expected to fall 19 percent, in line with the RAND experiment estimates of the savings from a 25 percent co-payment.

Using the four assumptions listed above, the low estimate of savings for a cost-sharing program in Alberta for 2001 is $831.23 million (table 6.6). In this scenario, patients would be responsible for $566.99 million while the province would pay $5.6 billion.

It should be noted that the savings estimated here are only those monetary savings that would accrue from the implementation of a cost-sharing program. As stated above, there are a number of non-monetary benefits that would accrue to patients from the implementation of a program. Other reforms might also lead to a reduction in expenditures while improving or, at least, not affecting patient care. For example, private competition in the hospital sector could lead to an increase in the number of services available without affecting aggregate expenditure, which suggests that expenditures could be reduced without decreasing output if a spending decrease and competition were to be introduced simultaneously. The same is true for hospital financing reform. In Australia, for example, the state of Victoria experienced a 14 percent increase in hospital

Table 6.6: Low Savings Estimate of a Cost-sharing Program in Alberta (2001)

Age Group	Spending Per Capita	Alberta Population	Exempt Population	Population in Program	Spending in Program ($ Millions)	Savings (%)	Savings ($ millions)
<1[1]	$1,257.96	24,221	2,339	21,882	$27.53	19%	$5.23
1–4[1]	$834.01	142,140	7,821	134,319	$112.02	19%	$21.28
5–14[1]	$789.52	434,952	11,118	423,834	$334.62	19%	$63.58
15–44	$1,449.48	1,440,336	181,726	1,258,610	$1,824.34	19%	$346.62
45–64	$2,254.07	739,956	51,638	688,318	$1,551.52	19%	$294.79
65–74[1]	$2,838.09	186,573	1,630	184,943	$524.89	19%	$99.73
75–84	$9,579.45	106,372	106,372	0	$0	0%	$0
85+	$17,768.07	31,916	31,916	0	$0	0%	$0
Total		3,106,466	394,560	2,711,906	4,374.91		$831.23

[1]Per capita spending does not include spending on hospital care.
Sources: Canadian Institute for Health Information, 2003a; Newhouse et al., 1993; Statistics Canada, Social Policy Simulation Database and Model; calculations by authors.

throughput while reducing the size of the overall hospital budget by 11 percent by switching to an output-based funding system (Duckett, 2000).

In an ideal world, the implementation of a cost-sharing scheme would result in substantial savings for taxpayers, both from the shift to patient payment and the reductions in total expenditures. But in Canada, the federal government reserves the right to enforce penalties for any province that implements a cost-sharing program because such a reform violates the Canada Health Act. According to the act, the federal government can either penalize the implementation of a cost-sharing program by withholding an amount in federal transfers equal to the dollars paid by patients in the province or withhold the entire cash transfer for health care by deeming the implementation of a cost sharing program a violation of the principle of accessibility (Esmail, 2003a). This leaves three distinct possibilities for the penalty that would be imposed if the provincial government were to make patients responsible for some of the cost of their care.

In the first scenario, the federal government could recognize that the problems with health care in Canada result from the design of the health care system itself, and thus it could do nothing to impede reform and experimentation. This would mean a decision to disregard the rules and regulations of the Canada Health Act and impose no penalty for health reform in Alberta.

A second, less optimistic scenario is that the federal government would strictly abide by Section 20 of the act, which allows the federal government to withhold a dollar amount equal to that charged to patients in the fiscal year. According to the estimates given above, this penalty would range from the low estimate of $566.99 million to the high estimate of $911.14 million, depending on the specific exemptions actually implemented.

The final and least optimistic scenario is that the federal government takes the implementation of a cost-sharing program to be a violation of the principal of accessibility. If such a decision were made, the federal government reserves the right to withdraw the entire cash component of transfers for health care. In 2001, this would have meant an estimated penalty of $958 million.[15]

If either of the first two penalty scenarios are the outcome of reform in Alberta, taxpayers could be better off. The range of savings from a cost-sharing program in Alberta is $831 million to $1.34 billion, while the potential penalties (in lost federal transfers) range from $0 to $958 million.

Medical Savings Accounts

While a cost-sharing approach can mitigate moral hazard and is conducive to competition and should result in a more efficient health care system, it also may entail regressive redistribution of income from the poor and sick to the wealthy and healthy, or it may impose a barrier to care that potentially endangers individuals' health, as discussed above. However, there is another idea that could achieve the benefits of cost sharing, while avoiding its drawbacks.

15 The federal government shares the cost of health services with the provinces through the Canada Health Transfer (CHT) and adds additional funds through the Health Reform Transfer and other transfers. Prior to April 2004, the costs of health services were shared through the Canada Health and Social Transfer (CHST), which also included federal transfers for post secondary education and welfare programs. Since the CHST has now been delineated, the estimated penalty given here is the proportion of the total transfers for all three programs listed above constituted by the CHT. Had a cost-sharing program actually been implemented in 2001, the federal government could have withdrawn the entire CHST (including transfers for post-secondary education and welfare), which was valued at $1.5 billion (Dept. of Finance Canada, 2004).

Medical savings accounts (MSAs) are health accounts that are established in conjunction with high-deductible health insurance. The Alberta government could provide its residents throughout the province with catastrophic insurance and deposit funds into MSAs. The size of the government contribution could be all, or a fraction, of the catastrophic insurance policy's deductible, depending on people's health status, age, and income level. Advocates of this approach believe that MSAs could induce competition in the medical marketplace without creating financial barriers to care.

While the government has since rejected the idea of medical savings accounts as a possible reform in the province (Government of Alberta, 2004a), the Premier's Advisory Council on Health for Alberta (2001) outlined how, in basic terms, a medical savings account system could be set up in the province.

> Individuals have a set amount allocated to their medical savings account for the year. This could be the equivalent of their health care premium (at whatever level that is set) or it could be a combination of their health care premium and additional funding from the province. The amount each person receives is adjusted for certain factors including sex and age. Government would continue to pay premiums on behalf of low-income people and deposit that amount in their medical savings account.
>
> Individuals could use their medical savings account to pay for insured health care services used during the year [including prescription drugs]… If individuals use up all the money in their medical savings account during the year, two options are possible. They could be required to pay for additional services up to an annual maximum amount (the so-called "corridor" between medical savings account coverage and the point at which medicare coverage kicks in). Or government would pick up all costs of needed health services just as they do now…
>
> At the end of the year, if individuals have not used all the money in their medical savings account, they get to keep it… Accumulated savings might be used to purchase a wider array of health services including services to help people stay healthy such as smoking cessation programs, dietary counselling, fitness training, or other services currently not publicly covered… (Premier's Advisory Council on Health, 2001)

Some of the potential advantages of MSAs include ensuring universal access to a minimum level of necessary medical services; increasing consumer empowerment and choice; economizing and rationalizing consumer demand for health services; accumulating savings against future unfunded health liability; increasing quality and decreasing costs through competition; expanding insured services; lowering overall costs to public sector budgets; and reducing health inflation (Skinner, 2002).

There is evidence from American firms and from Singapore's health system that MSAs are conducive to more prudent health spending without compromising individuals' health (Gratzer, 2002c; Ramsay, 1998). While there are studies indicating that MSAs could reduce expenditures by up to 20 percent in the United States, a RAND analysis concluded that "MSAs would be attractive to both sick and healthy people," and that enactment of federal MSA legislation could change total spending by between -2 percent and +1 percent (Ramsay, 1998; Miller, 1996).

Some of the potential disadvantages of MSAs include greater public expense if the system is

poorly designed; a loss of tax revenues from tax-deferred savings; greater expenditures from subsidizing those who make little use of the health system; and less equitable financing of health insurance and distribution of resources (Skinner, 2002).

Opponents of MSAs argue that individuals may delay seeking care or forgo preventive care when faced with medical expenditures and when allowed to retain any health care funds not spent in their MSA. Therefore, costs of the system will increase when these people end up requiring more expensive tertiary services. However, studies such as the RAND health insurance experiment discussed above have shown that, on the whole, cost sharing can reduce the use of health care services substantially with little or no net adverse effect on people's health status. Even if the use of certain important preventive services were negatively affected by the introduction of MSAs, these services can always be provided to all by the provincial government or the health regions.

Another argument against MSAs is that, due to consumer ignorance, physicians are able to induce demand. The importance of supplier-induced demand (SID) stems from the fact that even if cost sharing reduces the demand for health care and decreases expenditures at the individual level, it may not result in an aggregate reduction in use and costs because, when physicians and other health professionals see their revenue dwindle because of the introduction of cost sharing (or MSAs), they have an incentive to induce demand to restore their previous levels of income. In other words, SID will offset the effects of cost sharing. There is little doubt that the health care market is characterized by conditions conducive to SID, but there is great uncertainty whether SID is actually a large problem in the health care sector.

Ferguson (1994) provides a basic review of different interpretations of SID, examining market-level models (whether an increase in the number of physicians increases the use of health care and thus costs; whether the complexities of the health care market mean that the supply of care will never equal the demand for it; and whether inducement is more of an issue the closer the market is to a monopoly); models that use micro-level data, or individual-level models; studies that look at physician responses to price incentives (i.e., changes in the fee structure); and small area variation models (why geographic regions with similar populations and similar incidences of illness use physician services at different rates). He finds no support for the theory of SID, and noted that the methodology for most studies was poor (Ferguson, 1994; Skinner, 2002).

In another review of the SID literature, Feldman and Sloan (1988) conclude that SID may occur in the market for surgical services but its extent is less than previously estimated, and that there is little evidence for SID in the primary care physician market. Rice and Labelle (1989) argue that Feldman and Sloan omitted several important studies that contradict their conclusions and that physicians do indeed induce demand. Finally, Beck and Horne (1980) in their study of the effects of the introduction and removal of user charges in Saskatchewan (in the 1960s to early 1970s) find that the use of physician services declined with the introduction of user fees and gross payments for medical services increased, but they found no evidence to support or refute the hypothesis of SID. (As well, they found no significant differences in the probability that patients would be admitted to a hospital, or that their average length of stay would change with the introduction or removal of user fees.)

Newhouse (1993) suggests that there is strong evidence that even if physicians induce demand,

they will not be able to fully offset the decrease in demand arising from increased cost sharing. Finally, Tussing (1983) hypothesizes that patients are more likely to resist demand inducement when their out-of-pocket costs are high, i.e., providing individuals with financial incentives may make it harder for physicians to induce demand.

Admittedly, this lack of consensus offers little comfort to policy makers who must attempt to estimate physicians' response to the introduction of financial incentives in the Canadian health care system. The situation is further complicated when demand-side issues are added to the discussion, and when the proper design of a program—such as MSAs—is integral to the success of that program.

A recent article in the *Canadian Medical Association Journal* attempted to refute the potential of MSAs by demonstrating that a terribly designed MSA would fail (Forget *et al*., 2002). Using Manitoba data on health care access costs between 1997 and 1999, the authors showed that allocating each individual in the province the average physician and hospital costs ($730) as an MSA—thus assuming that all accounts would be the same regardless of age, sex, or health status—would lead to an overall cost increase. Critics have pointed out that the crucial flaw in this article is its lack of understanding about how an MSA would actually work. An appropriately designed MSA system would allocate funding for each citizen based on age, sex, and health status—an integral point missed by Forget *et al*. in their analysis of the MSA concept. Simply transferring the existing health budget to consumers will never work because the distribution of illness is not the same across the population.

Another key element of an MSA design is that most individuals must be responsible for the payment of at least some of their medical expenses. If an employer or government were to completely fund an MSA to the amount of the deductible, there may be better allocation of resources as consumers direct their funds to the health services that they actually use, but there will be little incentive for them to restrain their use of the system or to save for future health-care needs.

The value of cost-sharing is illustrated by Land and Schaafsma (2002). They developed an analytical framework and demonstrated that the savings/cost implications of an MSA program depend critically on factors such as the size distribution of health care expenditures, the MSA incentive effect (to reduce use of medical services), health care expenditure expectations and the incidence of illness. They assumed that at year-end the MSA surplus is withdrawn tax-free to be spent at will, assuming the maximum incentive for efficient spending (i.e., no portion returned to the government).

Using 1999 data for the 45- to 64-year-old Manitoba population and a variety of scenarios, Land and Schaafsma showed that MSA allowances are consistently more costly than medicare. However, throughout most of their analysis, the pair assumed that catastrophic insurance kicks in immediately once the allowance is used up, i.e., they do not include a corridor, because they disagree with the concept of a user fee on equity grounds. When a corridor of $100 was added to one of their scenarios (an $800 MSA provided by the government), the $26 per capita cost of the MSA plan changed to a $20 per capita saving for government. As well, they calculated a savings of $74 per capita for the government if it reduces its MSA allowance of $800 by $100 and requires individuals to deposit $100 so that the annual deposit remains $800.

Complete public subsidies can only be implemented with an MSA for small populations, such

as low-income earners. Individuals' personal tax-deferred, or tax-free, savings must fund MSAs for the rest of the population. Savings will only be generated if there is cost-sharing for the vast majority of the population or if the government is permitted to share in a portion of the balance remaining in an MSA at the end of the year (Litow and Muller, 1998).

Regardless of the size of potential cost reductions or savings to governments from an MSA program, the unspent funds are one of the most important components of MSAs. When some analysts (Hurley, 2001 and Forget *et al*., 2002, for example) consider the costs of an MSA program, they treat the personal savings as proof that MSAs are more costly for government. They underestimate the potential impact of the savings themselves. While health costs may not have been contained in Singapore by that country's Medisave program, the net assets in Medisave grew by about S$8 billion (or more than 60 percent) in the four years from 1995 to 1999 (Hanvoravongchai, 2002). In contrast, a country like Canada has no savings set aside for current health expenditures, let alone future costs.

Finally, surveys have shown that a majority of Canadians are willing to consider the idea of an MSA as a way to encourage responsible use of the system (72 percent), allow patients to choose services more suited to their needs (67 percent), and increase physician accountability (55 percent) (Angus Reid, 1997). Several researchers have laid out a plan for how MSAs could work in Canada (Gratzer, 2002a; Holle and Owens, 2000; Ramsay, 1998; McArthur, Ramsay, and Walker, 1996). The Consumer Policy Institute has constructed a detailed outline of a Canadian MSA system, including cost projections, potential changes in the use of various services, and a definition of insured and uninsured services (Litow and Muller, 1998).

Section 7: Recommendations

Many of the problems plaguing Alberta's health care system—waiting lists, lack of high-tech medical equipment, provider shortages, etc.—arise because health care in Alberta and the rest of Canada is organized mainly as a function of government and, therefore, increasing health care costs are problematic and must be contained. As such, exclusive public financing of medically necessary services has the potential to harm residents' health and hinder the future prospects of the health care sector, from which Alberta's economy could also benefit.

The ultimate goals of any health care reform should include the formation of a system in which population health is improved, people have access to medical services when they need them, consumers control their own health care decisions, and there is accountability (by both providers and consumers) for the use of resources. The following policy recommendations are made with these values in mind. The recommendations are grouped into two categories: those that fall within the current bounds of the Canada Health Act (universality, accessibility, portability, comprehensiveness, and public administration, as well as the many rules that define these principles), and those that would violate the Canada Health Act as presently written, but would do so without abandoning Canada's compassionate approach to health care.

Recommendations that fall within the current bounds of the Canada Health Act

1. **Privatize hospitals and other health facilities.** Canada lags behind most industrialized countries in encouraging various types of public and private hospitals to compete with one another for the opportunity to serve patients. Alberta contracts out approximately 0.15 percent of its total health care spending to private surgical facilities—there are no private hospitals. Currently, only one private facility, the Health Resources Centre, is approved for uninsured overnight stays (i.e., the centre is only permitted to offer care to patients who are not insured under the Canada Health Act, such as Workers' Compensation Board clients). Allowing more private providers to care for patients in Alberta would result in both improved quality of service delivery and reduced expenditures for publicly insured health care.

2. D**efine the roles of regulator, purchaser, and provider.** Rather than increasing the power of the provincial government, the minister of health should only act as the *regulator* of health care, the *funder* of the regional health authorities (RHAs) and the *monitor* of contractual arrangements between itself and the RHAs. The RHAs should act as the *purchasers* of health care services and the *monitor* of contract obligations between themselves, hospitals, and other health care facilities and groups of providers. Hospitals and health providers should be required to bid for contracts to provide acute care, primary care, or whatever care is demanded by the RHAs or individual patients. They should have an avenue for redress if the RHAs or the government break the terms of a contract.

   Regions should perform a population needs assessment, put out requests for proposals, and allow interested providers to prepare bids for various contracts. The RHAs would monitor the provision of the contracted services. The contracts with providers would establish desired outcomes. Those outcomes would be measured using such statistics as mortality and complication rates, infection rates, and patient satisfaction. The providers, not the RHAs, would determine the inputs used in the provision of health services—for example, how much labour to employ at a hospital, or how many diagnostic machines a provider group has.

   While Alberta has the structure in place for such a system, the minister of health still makes all of the final decisions. For example, under the province's Health Care Protection Act, the minister must approve all of the proposed contracts between RHAs and private surgical facilities. As well, the vast majority of RHA funding is from the ministry of health, therefore, ultimately the RHAs have limited autonomy to arrange potentially innovative cost-savings or quality measures specific to the population they are serving and, on the flip side, if the RHAs spend money irresponsibly, chances are that the ministry will bail them out with additional funding, making for weak incentives to be fiscally responsible. To support real efficiency, the system must be structured so as to reward high levels of performance, and penalize inefficiencies and poor quality.

3. **Introduce a new payment system for hospital and surgical services. Hospitals in Alberta receive an annual operational budget from the provincial health plan to fund the delivery of care, which allows the province to exercise control over hospital expenditures.** However, this scheme results in fewer services and a lower standard of care for patients because it disconnects the funding

from the provision of services to patients. Reforming this payment scheme would create powerful incentives to deliver a greater quantity and quality of services without leading to dramatic cost increases. This method of funding, best considered a prospective fee-for-service, or diagnostic-related group (DRG) payment system, is one in which the service provider is paid a fee for each individual treated, based on the expected costs of treating the diagnosis of the patient at the time of admission. A DRG-based payment creates incentives for hospitals to treat more patients and to provide the types of services that patients desire. It also facilitates the introduction of competition into the hospital sector because the cost of performing procedures is clearly identified.

4. **Remove all restrictions on medical school enrolment and withdraw subsidies for medical school education.** Much of the current physician shortage is the result of direct provincial intervention: longer training requirements, the downsizing of medical school enrolment, restrictions on international medical graduates, and the provision of retirement incentives. Part of the problem is also due to government decisions that have had the unintended consequence of reducing physician supply, such as expenditure control policies (caps on physician billings and hospital closures, for example).

   Planned alterations to the current admissions restrictions in Alberta will not resolve the problem in the long-term. Alberta must realize that the law of supply and demand has not been repealed for physician services. Abandoning the medical admission restrictions would mean that the supply of doctors would be determined by patients' needs, not on an arbitrary funding decision. By allowing medical schools to price medical training at cost and allowing admissions at the school to be determined by the school itself, students can decide if a career in medicine is profitable given open supply to the marketplace. Regions of Alberta where doctors are scarce could also opt to contract with students to provide health services for their area by offering to pay a portion of the student's school fees. Thus, doctor shortages will be mitigated as students would expect greater returns to their education (more patients available to attend the practice, patients with unmet health needs, etc.), while excess physician supply will have the opposite effect. The remaining causes of the doctor shortage, that of excess demand for medical services and prices set by government for medical services, cannot be resolved within the confines of the Canada Health Act.

   To change the system of medical education concerns not only health policy jurisdiction, but also post-secondary education policy, income tax policy, and the medical associations. It is not a change to be taken lightly but, as with the other recommendations offered here, it must be thoroughly studied and properly implemented

5. **Consider public-private partnerships (P3s) for the construction and operation of new health services infrastructure, in which the private sector participant can be a for-profit business or a nonprofit organization.** P3s are entirely in accordance with the Canada Health Act and there is evidence to support such partnerships. International experience indicates that P3s could result in more creative facility designs, cost savings, and lower lifecycle costs of between 20 and 30 percent relative to traditional procurement (Canadian Council for Public-Private Partnerships, 2003). Other reviews are more cautious about P3s and point to such potential problems as governments not properly enforcing contractual arrangements and governments con-

tracting with the private sector without considering competitively priced public ventures (Commission on Public Private Partnerships, 2001). However, most of these problems are related to inappropriate action on the part of governments and not the inability of P3s to provide new infrastructure at a lower cost than would have been possible without competitive bidding.

6. **Have citizens start a savings account for long-term care.** The proportion of Canadians older than age 65 is increasing in Canada, and Alberta is no exception. While the aging of the population may or may not indicate a future crisis in health care funding, seniors do consume more health care dollars than non-seniors, and it makes sense to prepare for that eventuality. This proposal is an adaptation of the recommendation made by the Clair Commission on health care in Quebec that its government take a comprehensive approach to the risk of long-term loss of autonomy (that is, the long-term health care needs for individuals unable to care for themselves) by using collective plans for funding universal services. The Clair Commission also proposed that the government manage the plan, although it noted that the funds must not be redirected to the province's general expenditures. The plan would be funded through a mandatory contribution based on personal income from all sources, as well as a portion of the funds that the government currently dedicates to long-term care services. Monetary benefits for home care would be determined, as needed, through the care plan and would be non-taxable in the hands of the beneficiary or recognized caregivers, depending on levels and circumstances to be determined (Commission d'étude sur les services de santé et les services sociaux, 2001). A full discussion of the tax implications of such a plan was beyond the scope of the Clair Commission report.

   Rather than a collective insurance plan, why not individualized savings accounts for long-term care that could cover home support and institutional care as well? Rather than having the government manage it collectively, individuals could determine how to use the account when they require care. An even easier proposal would be to abandon the limits to RRSP and RPP savings plans and allow withdrawals for health purposes, thus allowing a long-term care savings account to be implemented within current savings plan systems. There are currently mechanisms in place to protect someone's health and financial interests when they lose their autonomy and are unable to manage their assets, and these could apply to any savings account. Capitalization would guarantee the availability of adequate services for an aging population without placing undue stress on the coming generation to fund that budgetary burden.

7. **Open up access to all publicly held information on health care provider performance.** In Alberta, progress has been made in this area, at least with respect to waiting times. The online waitlist registry currently provides information on 18 types of surgeries or procedures. Visitors to the site can choose one of these, then pick which one of the hospitals that provides it, and they will be able to view a waitlist for individual physicians, which includes the number of patients waiting for that doctor for care type (inpatient or day patient) and priority. Also provided is the number of weeks within which most of the patients received service. The idea behind this registry should be extended to other aspects of the system, so that patients are able to choose which hospitals to go to for health services based on information about the relative effectiveness and quality of each to guide their decision.

Currently, in Canada, this type of data is being maintained by the hospitals and provincial ministries of health, and is now available in Alberta to providers and their licensing bodies, but is not readily available to the public. Making access to these data easier for research-oriented and consumer organizations would allow patients to find information about where the best health services are delivered and would allow institutions to compete on the basis of quality. Performance reviews done by government bodies and health authorities would not make an acceptable alternative to the free access of information because of the perverse incentives associated with doing a final review of your own performance.

Recommendations that would not be possible without violating the Canada Health Act

1. **Remove any and all restrictions on a parallel private health care system. At present, the private purchase of "medically necessary" health services is disallowed in Canada.** This policy choice ignores the evidence on the pitfalls of having a public monopoly in health insurance. Patients should be permitted to contract for private health care services in Alberta and be encouraged to do so through a program similar to that in Australia, Germany, or the Netherlands, where patients who contract privately for health services are partly reimbursed or exempted from paying the premiums that apply to the public health insurance scheme (Hilless and Healy, 2001; Mossialos *et al*., 2001; European Observatory on Health Care Systems, 2000). Actively encouraging the development of a private market could have many benefits for health services in Alberta, principal among which is better service for patients.

   The lack of choice in the health care system at present has resulted in a common and uncontested standard of health services, leaving patients in a situation where they have not been able to protest for better quality by choosing to purchase health services from a different provider. The monopolistic provision of health services in Alberta has abolished the need for hospitals to be efficient and innovative due to a lack of competition. Since patients have not been able to opt for higher quality accommodations, surroundings, or care, the public health system is not motivated to offer them (Boucher and Palda, 1996).

   Further, patients who buy private health services with their own money free up services in the public system for patients who are still waiting to get them. Increased resources could either be used to provide more care to public patients, or removed from the health sector entirely and given back to the citizens of Alberta in the form of a tax cut. Either way, the people of Alberta would be better off.

2. I**mplement a cost-sharing structure within the public health care system in Alberta.** When individuals do not face any direct charges for health care at the point of service, they have no incentive to restrain their use of health care. Such a situation can produce excessive demand for care and result in wasted resources, to the extent that the costs of producing these services exceed what individuals would be willing to pay for them. Co-insurance, deductibles, and co-payments can increase efficiency in the health delivery sector and reduce costs, and can reduce the tax burden of Canadians because they redirect health care financing from taxpayers to users. Since cost sharing can have an adverse effect on the health of the poor and the sick poor, these and certain other groups should be exempted from such a program.

3. **Move from the single purchaser model to a system of many competitive insurers where individuals are required to be insured for a basic set of health services.** A system of social insurers has a number of benefits over the general taxation model that has been followed thus far in Canada. The general taxation model, though administratively simple, suffers from a lack of transparency, as there is no easily established link between the payment into and the benefits received from health care. The lack of transparency also appears when an increase in the tax rate that is claimed to be for health services can be far larger in revenue terms than any increase in funding to health care. Also, a system with general tax financing and no cost sharing—i.e., care that appears "free" to the consumer—can lead to what Pauly (1968) described as an "inconsistency," where individuals demand health care as though it were free, and yet consider the positive costs of that care when voting on changes in tax rates. In other words, general tax financing can potentially lead to chronic shortages in health care financing.

   A social insurance system overcomes this drawback through a system of either public or private insurers (or some mix thereof) that provides health care to citizens once enrolled with the insurer. Universality is maintained through mandatory insurance enrolment. Although some tax financing may still be required to provide coverage by an insurer for the poor, the unemployed, and possibly the elderly, this system is less likely to suffer from politically-motivated intervention than a fully tax-financed system, as independent bodies collect the insurance payments and disperse the funds for health services. In addition, allowing users the choice of insurer, as the Czech Republic, Germany, and Switzerland do, has the added benefit of creating competition among insurers. Such choice generates efficiencies in the health care system as a result of competition and the possibility of varying cost-sharing schemes that allow lower insurance costs for those willing to pay more out of pocket. Countries that have opted for a social insurance system of finance appear to have fewer problems with the promptness of care than those who have chosen a tax-financed system (Altenstetter and Björkman, 1997).

   A recent comparison published in the *British Medical Journal* of Britain's publicly funded National Health Service with California's private, nonprofit Kaiser Permanente found that the per capita costs of the two systems, adjusted for such aspects as differences in benefits and population characteristics, were similar to within 10 percent. However, it found that Kaiser members experienced more comprehensive and convenient primary care services and more rapid access to specialist services and hospital admissions. Kaiser's superior access, quality, and cost performance was attributed to better system integration, more efficient management of hospital use, the benefits of competition, and greater investment in information technology (Feachem, Sekhri, and White, 2002).

4. **Deregulate the mandatory social insurance sector to permit the formation of medical savings accounts.** The Alberta government could provide its residents throughout the province with catastrophic insurance and deposit funds into medical savings accounts (MSAs). The size of the government contribution could be all, or a fraction, of the catastrophic insurance policy's deductible, depending on people's health status, age, and income level. The Premier's Advisory Council in Alberta described how, in basic terms, a medical savings account system could be set up in that province and the government should reconsider its recent rejection of MSA reforms.

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